07-03653 Daymond Sellers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aymona Sellers	1.	For State egistrar	or ivial yland / D	Certifica	te of	Death				g. No.	20	0.7	1500
Physicia	n/	. Decedent's Name (First, Middle,Last)	0-11				2	Month	Day \	/ear	3. Fime of 2241	1
ledical Examir		Daymond la. Facility Name (if not institution, give	etreet and number)	Selle		b. City, Town, or	Location of	Death	May 12, 20	4c. Coun	ty of Dea	J	
		St. Agnes Hospital	e street and number)			Baltimore					NA		
Funeral		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birth	day)	If Under 1 Year			8. Date of Bir	th(MM/DD/YY	YY) 9. E Fore	Birthplace (S	tate or
Director		NA 1X	M 2 F		Yrs.	Months Days		Min.	6-22	-2006			Md.
	- 1-	Usual Residence of Decedent	lan	. City, Town o	- Logotic	nn.						10d. Insi	ide City Limits
w any	- 1	10a. State 10b. County		•								1 X Y	es 2 No
Maryland 28a-f show	흱	Md. No. No. No. No. No. No. No. No. No. No	A	В.	aıt.	imore 10f. Zip Code			1	0g. Citizen of	What Co	ountry?	
or 28a	Director	3107 E. Biddl	e Street			212	213			US.	A		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once		11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was	s Decedent of His	spanic Origi	n? (Spe	ecify Yes or No		ace - Am	erican India	n, Black,
death v	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 X	No		es, specify Cubar		Puerto	Kican, etc.)				
after o	by F	3 Widowed 4 Divorced	or Dates:	1 1 100 5		Yes 2 X No		ind of w	ork done	Speci 16b. Kind o		Black ss/Industry	
1215-0036 d be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	-ted) 16a. L	Jecedeni Juring mo	ost of working life	e. DO NOT u	use retir	ed)			ŕ	
36 hin 72 e. than '	mpleted	Infant	Concept (vivier vivi		Inf	ant			4 11 7	NA			
5-0036 iled within 7 Hygiene. d other than the Medica	녌	17. Father's Name (First, Middle, Last					18.Mother's		(First, Middle,			a. 1	
21215-0036 July be filed within 72 Mental Hygiene. In marked other than ic event, the Medical	a	Thomas		Fangi	O	g Address (Stre	et and Num	Be	everly	Lun	n (Chesl	.еу _{de)}
D 2 should and Ma 7 is ma	٩	19a. Informant's Name/Relationship (Roger Ellis	Caretaker	1		7 E. B:							
m 2 d d Z m 2 d d Z m 2 d d Z m 2 d d d Z m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m	1	20a. Method of Disposition		20b. Place o	f Dispos	ition (Name of ce			Date	20c. Locat	ion - City	or Town, S	tate
imore, MD 2 Pages 1 and 2 shou ment of Health and I lant: If item 27 is n or other traumatic		1 X Burial 2 Cremation 3		King	ory or otr Me	m. Pk.		5-	-21-07	Ra	nda:	llsto	own, Md
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Specification 21 Signature of Funeral Service Lice	nsee / / /	7	22. N	Name and Addres	s of Facility	1	March	F.H.	East	t	
Ba pern Dep Imp		Joseph R.	Walters	W.	1	101 E.	Nort	$: h \mid I$	Ave.,	Balti	more	e, Mo	2120 eximate Interval
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	ach line.						r respiratory ar	rest, snook, c	i licari		veen Onset and Death
/Medical yaminer		Immediate Cause (Final disease of condition resulting in death)	Sudden unexpl	lained de	eath	<u>in infancy</u>	y (SUDI)				-	
			. Due to (or as a consequ	derice oi).								_	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	uence of):									
Ap. Bist	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):									
'60, *** iate be executed by sician and he burial - transit	E		ı. <u> </u>										
), be exe ician a urial -	Medical	XUNPENDED	#23a,27,28a	f. perM	E.g86	9. 7/24/0	7 TT_			22d D	ate of deli	ivery	
iox 68760, eath certificate be er attending physiciar for use as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	of pregnancy			Ectopi	c pregn	ancy	Mor		Day	Year
Box 687 e death certific the attending p ed for use as th	icial	past 12 months?	4 Pregnant at tir		-	other (Specify)							
Bo ne deat the at	Physician/	Part II. Other significant conditions	9 Olikilowii	out not resulting	a in the	underlying cause	e given in Pa	art I.	23e. Did	tobacco use	contribut	te to the cau	ise of death?
5.0. that the ned by detacl	by F	Part II. Other significant conditions	s contributing to death t	out not resonn	ig iii iiio	andonymy area	3		1Y	es 2 🗸 No	3	Probably	4 Unknown
ds, Fauires	ted								24a. Wa	is an is	24b. Wer	re autopsy f	indings available tion of cause of
COrc law re has be	Completed									formed?	dea		2 No
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the raster death. **Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ပိ	25. Was case referred to medical				26.Pla	ice of Death	(Check		,			
/ital	o Be	examiner?	Hospital: 1 Inpatient	2 V ER/0	Outpatier	nt 3 DOA	Other ₄	Nursi	ing Home 5	Residence		Other:	
of \officers of Physical Physical Interval	Ë	27. Manner of Death	28a. Date of Injury (Month, Day,Yea	/ 28b. ar)	. Time of	· · ·	njury at Wor	***		e how injury	occurred		
ion itendii leath. tor: /	atio	1 Natural 5 Pending 2 Accident Investig	FHU -2/ 14/	2007 Fn	d 9:4	+8 dm.l	Yes 2		unk	(Street and	Number	or Rural Ro	ute Number, City
IVIS lor At after d Direc	Certification:	3 Suicide 6 X Could n	28e. Place of Inju	ound: re			e building, e	etc.	or Town	. State)			sville, M
Dospital hours uneral	්	4 Homicide	inion. To the best of my	knowledge di	eath occ	urred at the time.	date and p	lace, an	d due to the ca	ause(s) and m	nanner as	s stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ner:On the basis of exam	ination and/or	investig	ation, in my opini	ion, death o	ccurred	at the time, da	ite and place,	and due	to the caus	e(s)
To To COU	₽ĕ	29b. Signature and title of pertifier	and manner stated.			29c. Lice	ense numbe	г				(Month, Da	ay, Year)
		1/CIAN	UV			0.0	C.M.E.			May 1	3, 200	/	
d		30. Name and address of person w	completed cause of de	ath (Item 23a)	111 0	onn Ctro-t D	altimore	MD	1201			-	
(h			sistant Medical Ex		11116	enn Street, B	ammore,	IVID Z	1201				
Regi	State stra	R/I/A T I 4 & L	07 Registrar	, ,,,,,	7								
DHMH 17 Rev 1			-	0	RIGIN	AL							

State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #29d, perMD, g867, 5/17/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Skipper william 78 2007 11:46 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Itar box 10017, tal 6 Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⋈** M 2□ F Months Days Hours Director 216-20-6066 80 JULY 31, 1926 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 ▼ Yes 2 No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 104 W. BARNEY ST 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or items edical Examiner n Black, White, etc within 72 hours after 1 Never Married 2 X Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH CEMENT MIXER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Mental is marked WILLIAM L. SKIPPER, SR. SARAH SPRIGGS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health HANNAH MAYO/DAUGHTER 104 W. BARNEY ST., BALTIMORE, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
Important: If iten
any Injury or oth 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison forest 5-7-07 Owing mills 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final Due to (or as a consequence of): **Physician** minutel disease or condition resulting in death) /Medical **Examiner** espirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 | Yes 2 | No 3 | Probably 4 Donknown Completed peen 24b. Were autopsy findings available prior to completion of eduse of death? 24a. Was an has le 2 page ; performe certificate 2 - No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA After this 2 funeral 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 28, 2007 (Item 23a) (Type, Print) Street, Baltimore, maryland 21225 300 anoser 31. Date filed (Month, Day, Registrar's Signature Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 05:20F Joyce Lee Speranzella MAY 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗶 F 58 213-52-5279 8/28/1948 Maryland Director Usual Residence of Decedent 10c. City, Town or Location works . 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Overlea MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 4321 Belmar Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Hunt Charles J. Kopriva 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4321 Belmar Ave Baltimore, MD 21206 James T. Speranzella / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Hilltop Serv. Corp. 5/19/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) METASTATIC CARCINOMA OF THE OVARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, list, and to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 🗷 No 9 Unknown 9 Hilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28h Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No

P.O. Box 68760. Division or Vital Records, or Attending To the Hospital

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Certification:

5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 Suicide 4 ☐ Homicide

29a. Certifier

Medical

State

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certified loy M.D

DØØ17695

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

ABDALLAH J 31. Date filed (Month, Day, Year) M. D. 7601 OSLER DRIVE TOWSON. MARYLAND 21204
Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

				State of M	arylario /	-	ificate of	Health and N ^f <i>Death</i>	лептат ну	Reg. No.	17	16004
	Physic	an	1. Decedent's Name (First, Middle, La Elizabeth Mar						2. Date of De Month 1		Year	3. Time of Death 6:50 AM
No. of Lot	/Medi Examir		4a. Facility Name (If not institution, give College Manor					4b. City, Town, or L Luthervi	ocation of Deat	h 4c. Count	t i mana	
Ì	Funeral Director		Social Security Number 6. S	ex 7. Ag	ge (In yrs. last 92		If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Bi	8, 1914	9. Birthp Coun N	lace (State or Foreign try) ew Jersey
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	tion					0d. Inside City Limits
	e Mary	ctor	MD Baltimo	re	Luth	nervil	1e					1 □ Yes 2 No
	ath with th	ral Dire	10e. Street and Number 300 West Semina	ry Ave.			10f. Zip Code 21093			10g. Citizen of USA	Whet Coun	try?
020	ba filed within 72 hours efter daath with the Maryland tall Hygiane. ud other than "natural", or items 23a or 28a-f show event, the Medical Examinan indist be indiffed at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:			as Decedent of es, specify Cu Yes 2 (2) No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	5 14. Rad Bla Specif	ce - Americ ck, White, e y: Wh	
15-0	n 72 h "natu	letec	15. Decedent's E (Specify only highest gre	ducation de completed)	16	Sa. Deceder	nt's Usual Occu	ipation during most of work ed)	ing	16b. Kind of B	usiness/Ind	lustry
212	filed within Hygiane. ther than " int, the Wei	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Homen		<i>90)</i>		()wn Ho	me
Maryland 21215-0020	should ba filed nd Mental Hygis marked other imatic event, II	To Be C	17. Fether's Neme (First, Middle, Lest, Charles M. Mars					18. Mother's Nam Genevi			ne)	
Man	12 sho h end l is me treume	·	19a. Informant's Name/Relationship (et end Number or Rur		-		
	s 1 end f Heelt ftem 2 other		Randy Low (daugh 20a. Method of Disposition		20b. Place	of Disposit	ion (Neme of	Road, Mo	Date	20c. Location		111 wn, State
Baltimore,	Page ment c ant: if lury or		1 ☐ Burial 2 🖄 Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif)	HiTTT	tőp Se	tory or other pl	Corp. 05	5/16/20	0 7 To	wson,	MD.
Bal	parmit. Pages 1 end 2 should by Department of Heelth end Menta Important: If item 27 is marked any injury or other treumatic events.		21. Signature of Funeral Service Licer	960			lame and Addi	ess of Facility Ru Road, Tow				lome, Inc.
			23a. Part . Enter the disease or com- shock, or heart failure. List only	lications that cause one cause on each li	the death. D	o not enter	the mode of dy	ing, such as cardiac	or respiratory e	errest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner	er	Immediete Cause (Final disease or condition resulting in death)	a. PNI	己UMO人 Due to (or as	,	nce of):				1	
· 68760,	tificata be executad 1g physician end as the burial-transit	fedical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as			7.4				
Box 6		an/Mec	rossining in south, East	d								
P.O. E	he daa' r the att ched fo	Physician/N	Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the unde	erlying ceuse g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
S, P.	s that t gned by se data	by Ph	ASCVD					an agrange	1 🗆	Yes 2. ✓ No	3 Prob	ably 4 ☐ Unknown
Division of Vital Records,	The law requiras that the death car ate has been signed by the attandir paga 2 should be datached for use	Completed b							24a. Wes	an autopsy ormed?	eva	re eutopsy findings illable prior to npletion of cause leath?
E E	: The l cate ha								10	Yes 2 No	1 🗆]Yes 2□No
Ĭ,	sician s cartifi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/0	Jutnotiont	3 DOA 0	her:		one) dence 6 □Oth	(Cit-	
n of	ng Phy fter this merel o		27. Menyfer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju		. Time of Injury	28c. Inju			how injury occur)
isio	death. ctor: A y tha fe	licati	2 Accident investigation 3 Suicide 6 Could not be		ury - At home	farm etreet		Yes 2□No	28f Location /	Street end Numb	er or Rural	Route Number
<u> </u>	tal or Ars efter ai Dire	Certification:	4 Homicide determined	building, et	c. (Specify)	14111, 311001	, raciory, onice		City or To		or or riara	riode Number,
	To the Hospital or Attending Physicien: The law within 24 hours eftar death. To the Funeral Director: After this cartificate has complataly filled in by tha funeral director, paga 2	edical	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	yelcian: To the best of liner: On the basis of and manner sta	examination e	ge, death or end/or Inves	ccurred et the t tigation, in my	ime, dete and place, opinion, death occurr	and due to the red at the time,	ceuse(s) and madate and plece,	anner as sta end due to	ated. the ceuse(s)
	Total With	Σ	29b. Signeture and title of certifier	. MD				se number		29d. Date signe		-
	a		30. Name and address of person who	completed cause of d	eath (Item 23a	ı) (Type, Pri	nt)	- /		may.	1	
	18		C. VERGARA - SOAV	2ES 30	OW.	SEMI	NARY	AVE LU	THERVI	ILE, ML	7. 210	193
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 2007	32. Registr	ar's Signeture	parti	5	LVE LU				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year JOSEPH SEYMOUR 11:23 PM MAY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUS PITAL NORTH WEST RANDALLSTUL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 220-74-7578 65 <u>August 19, 1941</u> Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Markland Economic Processing States of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Director Randallstown 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9909 Hoyt Circle 21133 Funeral United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A Disabled Disabled 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Ernest Seymour Kathleen Bartelle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene Hall (Chimes Inc. Admin) 4815 Seton Drive, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. May 17,2007 Catonsville, MD 21228 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMUNIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Mknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 20 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural Certification: 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) M.D. D57722 2007 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 5401 GLD COURT ROAD RANDALLSTOWN MD 21133 LEONARD RICH ARDSON 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #788 perFH, 68/6, 2/28/08 TT

Continue Amend #788 perFH, 68/6, 2/28/08 TT 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Ruth Corinne Smith 1:43 PM 2007 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1925 9. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 81 112-20-2732 Director November 13, 1927 New York Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at N/ADirector Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5409 Springlake Way 21212 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) event, the office manager medica1 permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If Item 27 is marked other I any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Skell Agnes Nordgren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Meredith Smith Jr./husb. 5409 Springlake Way Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory May 16,2007 | Baltimore, Maryland 21. Signature of Funeral Service Licenses & 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, 23a fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** My o cordial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of deniying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physiclan Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) Day Year 4□Pregnant at time of death the þ signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate l performed' 2□ No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No မှ 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending ithin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 may 14, 2007

DHMH 17 Rev 1/2001

State Registrar Loch Raven Blvd.

32. Registrar's Signature

21239

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601

Teresa Muns, M.D.

31. Date filed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

MAY 1

7 2007

Jorrell, Constance

Medical

32. Registrar's Signature

Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lunshington

Physician /Medical Examiner

Martha

2

Knowh

Patient Maryland

21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Certification: To Be

Medical

State

Division or Vital Records, P.O. Box 68760,

					1 Yes 2 No	1 ☐ Yes 2 ☑ No						
25. Was case examiner?	referred to medical	26. Place of Death (Check only one)										
1 ☐ Yes	2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3 □ DOA	Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of 1 ☑ Natura 2 ☐ Accide	al 5 ☐ Pending ent investigation		28c	: Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury o	ccurred						
3 ☐ Suicio 4 ☐ Homi		28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, o	office	Number or Rural Route Number,							
29a. Certifier (Check or		nysician: To the best of my knowledge, death miner: On the basis of examination and/or inve										

01.07	and manner s
29b. Signature and title of certifier	MA A

29c. License number RES-000 29d. Date signed (Month, Day, Year) 6,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO Hospital of Baltimore Sinai Zingman

31. Date filed (Month, Day, Year) 200 3 Registrar's Signature

600

KIDAR

State of Maryland / Department of Health and Mental Hygiene 3. Time of Death 2007 12:30 PM 4c. County of Death Anne Arundel Birthplace (State or Foreign Country) 1924 Maryland 10d. Inside City Limits 1√2 Yes 2 □ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry <u>Dry Cleaning</u> 21401 20c. Location - City or Town, State Crownsville, Md. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Found 3 Time of Death 1. Decedent's Name (First, Middle, Last) 6:45PM -2007 **Physician** EORGE IMPSON /Medical 4c. County of Death 4a. Facility Name (Innot institution, give street and number) Sity, Town, or Location of Death Examiner atonsville altimore Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday If Under 5. Social Security Number **Funeral** 80 MD 1 XM 2□ F 215-20-946 Director Usual Residence of Decedent 10d. Inside City Limits 10c_City, Town or Location 10a. State 10b. County or 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 208 Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 20 No Baltimore, Maryland 21215-0036 ŏ Specify Specify: Blar þ 3 ☐ Widowed 4 ☐ Divorced "neture!", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ye. DO NOT use retired) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. penter Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental P Walter Vladessa limpson impsor) ဥ Route Number, City or Town, State, Zip Code) 19b. Mailing Addr 19a. Informant's Name/Relationship (Type, Print) eet and No of Health an 26810 20872 thompson, Sr. mascus Jon 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or otl 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ci latil file, Baltmore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 yrs Coronar **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an s certificete has b autopsy 200 1 ☐ Yes 1 Yes 2 No or Attending Physician: After this certification funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 5 Residence 6 Other (Specify) 2 No 4 Nursing Home Certification; To 1 Tes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending s after death. 1 Tyes 2 □ No investigation the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funerel (Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO063 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person why Baltimore MD 10 N. Greenest. Johns

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

MAY 1

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 15 JEAN M. TALIAFERRO MAY 2007 8:15a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 301 BRIGHTWOOD CLUB DR. LUTHERVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/19/1907 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 1 □ M 2 KF 99 220-44-4752 Yrs. MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 301 BRIGHTWOOD CLUB DRIVE 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No $^{\textit{Specify}} \dot{\textbf{WHITE}}$ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12YRS College (1-4or 5+) HOUSEWIFE HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) AUSTIN McLANAHAN ROMAINE LEMOYNE 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE T. WHITRIDGE (DAUGHTER) 10613 CANDLEWICK RD. STEVENSON, MD. 21/53. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 05/19/2007 OWINGS MILLS, MD. THOMAS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. JENKINS & SONS CO YORK RD MONKTON, MD. HENRY 16924 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): cellulits Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury cell cascinone namous resulting in death) Last Due to (or as a consequence of) IF FEMALE

Examine requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-trar Division of Vital Records, P.O. Box 68760 Physician/Medical s been signed by the à Completed To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. Be Certification:

Physician

/Medical

Director

þ

Completed

Examiner

Funeral

Director

r then "naturel", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "na any injury or other treumatic event, Ina Madia 2008.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of a 9 Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year			
De men to	contributing to death but not re-	sulting in the underlying	g cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
				24a. Was an autopsy performed?				
25. Was case referred to medical			eath (Check only ne)					
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 esidence 6 Other (Specify)				
27. Man r of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	jury occurred			
3 Suicide 6 Could not 4 Homicide determine			ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Physician: To the best of my kn aminer: On the basis of examin				(s) and manner as stated. ind place, and due to the cause(s)			

29c. License number

D47129

29d. Date signed (Month, Day, Year)

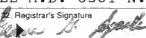
Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D. McCONNELL M.D. 6301 N.

CHARLES ST. BALTO., MD. 21212.

31. Date filed (Month, Day, Year) State 7 2007

29b. Signature and title of certifier



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month MAY **Physician** ROBERT MASON THOMAS 15, 11:50a[™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | MAY 29, 1 7. Age (In yrs. last birthday). 86 Yrs. 5. Social Security Number 217-18-8101 9. Birthplace (State or Foreign **Funeral** 1 💢 4 2 ☐ F MARYLAND **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" ~ " any injury or other treumatic avairable. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD BALTIMORE PHOENIX 1 ☐ Yes 2 ☐No Directo 10e Street and Number 2720 MERRYMANS MILL RD 10f. Zip Code 10g. Citizen of What Country? 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE Specify ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ATTORNEY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HENRY BRISCOE THOMAS ANNE MASON BANKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 WARREN SQ. JAMAICA PLAIN, MA 02130 ROBERT M. THOMAS, JR. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State MAY 18, 2007 BALTIMORE GREEN MOUNT MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD 21111 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** - emerchagic hours /Medical Due to (or as a consequence of): Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit To the Hospital or Attanding Physicien: The law requires that the deal certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has 1 ☐ Yes 2\No 1 Yes 25. Was case referred to medical Be 26. Place of Death | Check only one | examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient After this c Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 □Yes 2 □No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide TECHTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) the S 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) Nº C D0063044 Name and address person who completed cause of death (Item 23a) (Type, Print) GREENE ST. BALTIMORE, MD. S. (hil 31. Date filed (Mon 32 Registrar's Signature 7 The State of 2007 Registrar

			State of Maryland / Dep		Mental Hy	giene	10012
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Dea	Reg. No. UU/	3. Time of Death
ı	Physici		Thomas E. Thommen		May 9,	Day Year	11:00 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Dea	
			Charlotte Hall Veterans Home	Charlotte Hall	L	St.	Marys
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day	h 9. Bir v, Year) C	thplace (State or Foreign ountry)
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	/land		10a. State 10b. County 10c. City, Town or L.	ocation			10d. Inside City Limits
	Man a-fsh	ţċ	Maryland St. Marys Charl	otte Hall			1 ☐ Yes 2X No
	ith the or 28	Directo	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	ath w		29449 Charlotte Hall Road	20622		U.S.A.	
	ltems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 1 ▼Never Married 2 Married 1 1 ▼Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
99	urs aff	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 【XNo Specify:		Specify: W	hite
2-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-1 show ha Madteal Eva rither must be rollited at	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	rking	16b. Kind of Business	
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2	filed w Hygier other th			undskeeper		Baltimore	County
anc	d be fi	Be	17. Father's Name (First, Middle, Last) Francis Victor Thommen, Sr.		me (First, Middle, zabeth	Maiden Sumame)	tom
Maryland 2121	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28a-f show other traumatic event, the Madical Examinar must be notified at	ို		ng Address (Street and Number or R		Lup or, City or Town, State.	
	and 2 is				rlin MI		
Je,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition		Date	20c. Location - City or	Town, State
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Miller-Dippel I	Tuneral H	lome. Inc.	
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r			23a. Part1. Enter the disease, of emplications that caused the death. Do not en shock, or heart failure. List only one stuse on each line.	ter the mode of dying, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death
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ā	s afte	Certification:	4 Homicide determined building, etc. (Specify)		City or Tow	n, State)	
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	the hin 24	Medi	one) and manner stated.				
	T WH		29b. Signature and title of centrier	29c. License number	έ	29d. Date signed (Mont	ii, Day, Teal)
			30. Name and address of person who completed cause of death (Item 23a) (Type,	D005757	}	راف راب	
	3.4,			Hall Rd. Charlo	tte Hall	MD 20622	<u> </u>
	Sta	te			Jul Harr		
	Registr	ar	31. Date filed (Month, Day, Year) MAY 1 7 2007 32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician KATHARINE HARRIS vanHOGENDORP 12:40 15 2007 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Baltimore County BLAKEHURST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb | 14, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 💢 F Maryland 96 212-28-6164 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-1 ehow ir than "natural", or items 23s or 28s-f ehor the Madical Expirition must be putified at 1 Yes 2 No Director Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 IISA 1055 West Joppa Road by Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: White If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Flementary/Secondary (0-12) Coffege (1-4or 5+) Author/Musician Self-Employed other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Katharine Mathaei Carlton Danner Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health Anne W. Rienhoff 7802 Ruxwood Road, Baltimore, MD 21204 (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition \$ = 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ö Department of Important: If eny Injury or once. Druid Ridge Cemetery 5/19/2007 Pikesville, Maryland 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 21. Signary (Fineral Styles Icansee Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opeet and Death Immediate Cause (Final disease or condition resulting in death) heime Physician /Medical Due to (or as a consequence of) Examiner Sequentially list anditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician s the burial Physician/Medical anding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten Month Day in the past 12 months?

1 Yes 2 No
9 Unknown ō 5 Other (specify) 4 Pregnant at time of death signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 🗌 Yes 2 2 No 3 Probably 4 Unknown been signated by the second of Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 200 No 1 Yes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Certification: 27. Manner of Death Injury 1 Natural 5 Pending within 24 hours after deaun.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ro the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier celellul lecan 2007 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III M.D.6301 North Charles Street, Baltimore, MD 21212 Iredell W. Iglehart, 31. Date filed (Month, Day, Year) State 200 De the said Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			i- For State Registrar	Certificate of	of Death		Reg. No.	200	1 1001				
	Physici		Decedent's Name (First, Middle,Last)			2. Date of	f Death	Year	3. Time of Death				
<u>J</u> edica	l Exami	iner	JEAN SANDRA WATSON			May 8	3, 2007		2005 hrs				
			4a. Facility Name (if not institution, give street and nur	nber)	4b. City, Town, or Lo	cation of Death	4c.	County of Death	1				
			3800 W. Belvedere Apt. 1124		Baltimore								
	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. 8. Date Hours Min.	of Birth(MM/D	Foreig	thplace (State or an				
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:	eath with the Maryland items 23a or 28a-f sho ust be notified at once.	era	11. Marital Status 12. Was Deci	edent Ever in U.S. 13. V		nic Origin? (Specify Yes lexican, Puerto Rican, et		 Race - Amer White, etc. 	ican Indian, Black,				
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	safter ral", iner	by	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		Yes 2 X No s			Specify: BL					
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0	l with giene ther t	mo.	12th 17. Father's Name (First, Middle, Last)	CLE		Mother's Name (First, Mi			טי				
21215-0036	e filed al Hy cedol	Be C	ANTONIO FONSEIGAR			KATHERINE DI		,					
21;	uld b Meni mari c eve	10 5	19a. Informant's Name/Relationship (Type, Print)	19b. Mail		nd Number or Rural Rou		y or Town, State	e, Zip Code)				
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rds	w requires that is been signed should be deta	ompleted				24a	. Was an		utopsy findings available completion of cause of				
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,	To the Hospital or Attending Physician: The law requires that the death certifi within 24 detected that the certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it.	ledical	one) 2 Medical Examiner: On the basis of and manner s	of examination and/or investi	gation, in my opinion, d	leath occurred at the time	e, date and pla	ce, and due to t	he cause(s)				
	- × - 5	ığ	29b. Signature and title of certifier		29c. License	number	29d. I	Date signed (Mo	onth, Day, Year)				
			the limin-	1600-L.	O.C.M	E.	May	9, 2007					
	.t.	1	30. Name and address of person who completed caus	e of death (Item 23a)									
	\$			int Medical Examiner	111 Penn Stre	et, Baltimore, MD	21201						
			31. Date filed (Month, Day, Year) Re MAY 1 7 2007	gistrar's Signature	ME								
	Regis	ureli	MINI T (VOO!										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM#5 per IL G867.5/17/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:25 AM 2007 ARTHUR NATHANIEL WATKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2 □ F 213-90-0400 Yrs Director 31, 1946 MD 61 JAN. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 TYYes 2 □ No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 317 E. NORTH AVE. APT. #408 21202 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: BLACK Specify Be Completed by 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7TH CNA HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ARTHUR WATKINS, JR. မ VIRGINIA ROBINSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LATONYA SHOWELL/DAUGHTER 3132 EAST AVE., BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5712 O DONNELL ST. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/18/2007 BALTIMORE, MD 21224 MOUNT CARMEL 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licensee ran 2007-09 EASTERN AVE., BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 yrs Nowall /Medical Due of (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending pl the þ signed t certificate I Physician: this After or Attending death. 24 hours after death Funeral Director: Hospital

Maryland 21215-0036

Baltimore,

within 2

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ve A

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 7 MAY 1 2007

round

Union Memoria 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

				State of Maryland	d / Depa	artment of H	ealth and N	-	_	16017
			State Registrar 1. Decedent's Name (First, Middle, Last)	,	Cel	tificate of L	Jeath	Reg 2. Date of Death	. No.	2 To 2 1 5
	Physici /Medic		Carolyn L	White				Month Man	Day 7 100	
7	Examin		4a. Facility Name (If not institution, give st	reet and number)	Λ . Ι	4b. City, Town, or	Location of Death	9	4c. County of Deat	
			5. Social Security Number 6. Sex	7. Age (In yrs. 12	& Cent	If Under 1 Year	If Under 24 Hrs.	9 Date of Righ	N/	
	Funeral Director			M 2♀F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)
			Usual Residence of Decedent	67				May 11,1	940 Ma	ryland
	irylan ihow	_	10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits
	8a-f.s	Director	*	imore			Dundalk			1 ☐ Yes 2 🔀 No
	with th	<u>Sign</u>	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	e 23	eral	3030 Liberty Pkwy	7 . 2. Was Decedent Ever in U.S	2 12 1	Man Danadast of Hi	21222		nited Sta	
	fter d	Funeral	11. Marital Status 12 Never Married 2 Marned	Amed Forces? 1 ☐ Yes 2 ☑ No	3.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	
93	al', o	þ	3 ☐ Widowed 4x Divorced	If Yes, Give Year or Dates:		I⊡Yes 2½∏No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland Insturel', or Iteme 23a or 28e-1 show Uical Examiner must be natified at	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	lent's Usual Occupa	ation	ring 16	b. Kind of Business/	Industry
121	within ene. then *	d E	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I	kind of work done o OO NOT use retired,)			
	e filed v other t vent, II		17. Father's Name (First, Middle, Last)	2 Years		Nurse	18 Mother's Nam	e (First, Middle, Ma	Nursin	g
Maryland	d be and a lead of the control of th	To Be	Carroll Schafer				TO. WICHIO STAM		a Murphy	
7	shoul nd Me nark	μ.	19a. Informant's Name/Relationship (Type	ə, Print)	19b. Mailir	g Address (Street a	and Number or Rur		ity or Town, State, 2	Tip Code)
	alth a		Erick C. White	(Son)	3030	Liberty	Pkway.	Dundalk,	Maryland	21222
ore	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	20b. Pla	ace of Dispo	sition (Name of natory or other place	9)	Date 20	c. Location - City or	Town, State
Ĕ	Peges ment of ant: If it ury or o		4 □ Donation 5 □ Other (Specify)	novarnom state		Service C	l l	4/2007	Towson, M	aryland
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show emportant: in the 23a or 28a-f show in yiluy or other traumatic event, the Mardical Exeminar must be notified at once.		21. Signature of Funeral Service Licenses	Can	D	Name and Addres uda-Ruck 922 Wise	Funeral	Home of ndalk, Ma	Dundalk, ryland 21	Inc. 222
			23a. Part1. Enter the disease, or complice shock, or heert failure. List only one	ations that caused the death.						Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due le (or as a conseque	ence of):	1 1 1) ^			·
		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Respire for C	en-	d Metal	polic H	cidosis		2 hours
	nsit	nin	cause. Enter Underlying Cause (Disease or injury that initiated events	A. to Pa	(- ()	Failur				4 60000
, O	be executed icien end burial-transit	Examiner	resulting in death) Last	Due to (or as a consequent	ence of);	10011017				1,10013
3760,	s s	cai	U d.							
89 J	ing ph	Med	IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnan 1 Live birth 2 Fetal	death 3	Ectopic pregnancy			23d. Date of deli	very Day Year
P.O.	The law requires that the death certifica site has been signed by the attending phage 2 should be detached for use as the	Physician/Med	1 ☐ Yes 2 D\No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	ath 5∟	Other (specify)		-	, worth	Suy . Gui
0	s that ned b e deta	by Pr	Part II. Other significant conditions contr	ibuting to death but not resul	lting in the ur	nderlying cause give	on in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Vital Records,	en sig	ed b	COPD					1 ☐ Yes	2 □ No 3 □ Pr	obably 4 MUnknown
900	e law re has be je 2 sho	Completed	CHF					24a. Was an	24b. Were au	topsy findings available
Œ.	The ete h page	E OC	CAD					autopsy performe 1 X Yes 2	d? death?	completion of cause of 2DYNo
/ita	clan: entific ector,	Be	25. Was case referred to medical examiner?					h (Check only one)		
o	Physic this c	2	1 Yes 25 No		R/Outpatien		4 Li Nursing Ho		e 6 □Other (Spec	ufy)
Division of	ding h. After funer	tlon	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? ∕es 2 □No	28d. Describe how	injury occurred	
/S	Atten r deat ector: by the	flca	3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne, farm, str		2 2 2 110	28f. Location (Stree	et and Number or Ru	ral Route Number,
Ö	s after	Certification;	4 Homicide	building, etc. (Specify)		, ,		City or Town, S	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate had ownpletely filled in by the funeral director, page	edical	29a. Certifying Physic (Check only one)	cian: To the best of my know ir: On the basis of examinate and manner stated.	rledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the	M	29b. Signature and title of certifier			29c. License		29d	Date signed (Month	, Day, Year)
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			30. Name and address of person who see	pleted cause of death (Item	23a) (Type,	Print)	0 11	LTU.AT	0	0.1
1	`		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	a Start		Saltim	re, MD	2190	7 _
	Sta Registr		11. Date lieu profilit, Day, Teal)	oz. negistrar s Signatu	Low					
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07-03676

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dawn L. Williams State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ May 13, 2007 1652 hrs Medical Examine Williams 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Foreign Country) Maryland Months Days Hours Min. Director 214-64-3122 2 X F 52 04/04/1955 М Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 23a or 28a-f show notified at once. Maryland Anne Arundel Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Atlanta Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married Never Married Yes 4 X Divorced if Yes, Give Year 1 Yes 2X No specify: Specify: White þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 Merchant Seaman 12 N/A Seafarers Union 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked or injury or other traumatic event, the Rowland [] Williams Doris Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Lee Williams (Mother) 219 Atlanta Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery Baltimore, Maryland 05/18/2007 Donation 5 Other Specify Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licensee Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Heroin and diphenhydramine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician for use as the burial AMED DED 27,28a-f, perME, g868, 6/7/07 TT Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Other: Inpatient 2 S ER/Outpatient 3 Nursing Home 5 Residence 6 After this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 X No Pending 24 hours after death the Fnd 5/13/2007 Fnd 1:30 pm unk 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide 219 Atlantic Rd. Glen Burnie, MD (Specify) found at residence Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within To the one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number May 14, 2007 O.C.M.E. ens 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

OCME 2006

Registrar Drivin 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5-07 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** Days Months 1□M 2**X**F Director 1010 death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f shov must be notified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 12. Was Decedent Ever in U. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mentai Hygiene. Int: If Item 27 is marked other than "naturai", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify Black 3 Widowed 4 Divorced Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) sembly reneral 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21 060 19a. Informant's Name/Relationship (Type. Print) Cornway 20b Place of Disposition (Name of cemetery, crematory or other place) Iriplin 20a. Method of Disposition Department of I Important: If Ite any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07 21. Signature of Funeral Service Licen 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of bring, such as cardiac or respondock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cellung **Physician** Non Stechi Smonth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician ast attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No 24a. Was an certificate has autopsy 1 Yes 2 No or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 No ပ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t determined 4 Homicide the Hospitai Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier D#2230 16-200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SIVASAIVAN

MAY 1 7 2007

32 Registrar's Signature

Sperles

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208, Baltimose Mid-2123

-03699 arlon Winder		Please Type or Print in Black Indelik State of Maryland / Departme	ole Inl	k. Ensu	re All Co	pies Are Leg	gible.	007 1602			
		1- For State Certifica				Re	eg. No.				
Physicia I Examir		Decedent's Name (First, Middle,Last) MARLON WINDER				2. Date of Dear Month May 14, 2	Day Year 007	3. Time of Death 0700 hrs			
		4a. Facility Name (If not institution, give street and number) Sinai Hospital	46	. City, Town, Baltimore	or Location of	Death	4c. County of	Death I/A			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day)	If Under 1 You		24Hrs. 8. Date of Bir	th(MM/DD/YYYY)	9. Birthplace (State or			
Director		213-90-2351 1XXM 2 F 44 Usual Residence of Decedent	Yrs.	Months	lys i Hours	08/04/	/1962	Foreign County,RYLAND			
w any		10a. State 10b. County 10c. City, Town of	or Location	n				10d. Inside City Limits 1 X Yes 2 No			
Maryland 28a-f show d at once.	Director	MARYLAND N/A BALT: 10e. Street and Number		E 10f. Zip Code		1	0g. Citizen of Wha				
ith the M 23a or 2 notified		3012 FALLSTAFF ROAD APT E			209		U.S.A.				
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72 hour n "natii al Exan	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12yrs 2yrs CHEF 18. Mother's Name (First, Middle, Last) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOI 17. Father's Name (First, Middle, Last)										
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21215-0036 Muld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho e event, the Medical Examiner must be notified at once.	Be	DAVID HICKS			RITA	WINDER					
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Baltimore, permit. Pages I ar Department of Hee Important: If iter injury or other tr		4 Opnation 5 Other Specify: NEW CATHEDRAL CEMETERY 05-21-07 BALTIMORE,									
Ba perm Depa Imperinjur		WILLIAM C BROWN COMMUNITY FUNERAL HOME 1206 W NORTH AVENUE									
hysician Medical		23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Head injuries complicated by hypoxic ischemic encephalopathy									
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Read injuries complic Due to (or as a consequence of):	<u>ateu</u>	<u>Бу Пуро</u>	CIC ISCHE	aiuc encepna.	LODALITY				
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Box 68760, e death certificate be the attending physic of for use as the buri	Physician/Medic	past 12 months? 1		er (Specify)				,			
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2 an 2	Completed	disease, chronic pericarditis					opsy pormed? d	rior to completion of cause of leath? Yes 2 No			
ion of Vital Rectending Physician: The leath. for: After this certificate the funeral director, page	Be Co	25. Was case referred to medical examiner?			ace of Death (Check only one)					
n of Vital ding Physician: After this certif	ပို	1 ✓ Yes 2 No Properties 1 ✓ Inpatient 2 ER/0 27. Manner of Death 28a. Date of Injury 28b.	utpatient Time of Ir		njury at Work	Nursing Home 5 28d. Describe	Residence 6 how injury occurr	Other:			
Sion Attending r death.	5 1 Natural 5 Pending Fnd 5/11/2007 Fnd 5:35 pm 1 Yes 2 No unk										
Divis ital or A ital or A rat bire	Certification:	3 Suicide 6 X Could not be determined (Specify) house	arm, stree	t, factory, offic	ce building, etc	or Town, 3012 Fal	(Street and Number State) Llstaff Rd,	er or Rural Route Number, City Baltimore, MD			
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	ical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, decoded one) 2 Medical Examiner: On the basis of examination and/or i	ath occur nvestigati	red at the time	, date and pla	ce, and due to the car	use(s) and manner	as stated.			
To t To t	Medical	and manner stated. 29b. Signature and title of certifier			ense number			ed (Month, Day, Year)			
		aues2		0.	C.M.E.		May 15, 20	07			
Ø		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111	Penn S	treet, Balti	more, MD	21201					
		31. Date filed (Month, Day, Year)	south	,							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 2007 Year Month ROBERT DENNIS WEISHAAR MAY 15, 4b. City, Town, or Location of Death 4c. County of Death WESTMINSTER CARROLI If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Year) 1 XM 2 □ F 10/10/1950 56 10c. City, Town or Location 10b. County

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** P^{M} 2:51 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 2802 RAINBOW DR. 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Director 213-52-5378 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2802 RAINBOW DR. 21157 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2 📉 No δ SpecifyWHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n 27 is marked other than "ar traumatic event Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES MARVIN WEISHAAR, SR. MARY LOUISE WADDELL ဥ Health and N tem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) -WIFE DEBORAH L. WEISHAAR 2802 RAINBOW DR., WESTMINSTER, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 5/19/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State □Donation 5 Nother (SpecifyENTOMBMENT EVERGREEN MEM.GARDENS FINKSBURG, MD Furural Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Opent and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a q quence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed ing physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 Probably 4 □Unknown 2 🗌 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performed Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2**□** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No after death.

| Director: / 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature ar 29c. License number sianed (Month title of certifier 29d_Date Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Westminuter, MD 2115 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** - 20 PM 200 Widerman 10 William Robert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEZ EL Salhmore Washington MEDICAL CE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Se: 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 212-42-0149 MD 10 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 193 10th Street 21122 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: 3 Widowed 4 Divorced item 27 is marked other than "natural"; other traumatic event, the M-dical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Union Local #355 12 should be filed v h and Mental Hygie 7 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Widerman Marjorie Laukaitis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an ant: If item 27 Is Lisa L. Widerman (spouse) 193 10th Street, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any Injury or of May 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Metro Crematory Inc. 2007 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Funeral Service ticense 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Pan'1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death METASTATIC Immediate Cause (Final hysician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed ing physician and as the burial-trans Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the aid 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Wunknown cate has been si 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 2 No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: : After 1 Natural 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Directors A completely filled in by the fo death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature Hile of certifit 345149

State

Registrar

31. Date filed (Month, Day, Year)

and a

32 Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

three Specific

Ave Glen Burnie MS Dorli

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760%Hospital or Attending Physician:

the bunal-tran physician attending p as ed by the a detached f sate has been signed page 2 should be det funeral director, After this 24 hours after death Property Process: filled in by within 24

Funeral

Director

or 28a-f show notified at

must be n death with

ural", or items 2

"natural"

7 is marked other than "natu traumatic event, the Medical

Item 27 is other tra

Department of H Important: If Ite any Injury or ot once.

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

altimore, Maryland 21215-0036

the Maryland

0

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARANDRKAN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)



WO

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D47611

29d. Date signed (Month, Day, Year)

May 10, 2007

TANEY AVE # 204 FRETHICK MD 21702

		4	For State Registrar	viai yiailu /		ificate of E			eg. No.	O 137 1	1 3	/ 1	
	Dhysinia		. Decedent's Name (First, Middle, Last)					Date of Deat Month	Day	Year	3. Time of I		
	Physicia /Medic	al	RUTH ELINOR ANDREW			4. O. T	Land of Dooth	MAY	12	2007 hty of Death	4:45	P^{M}	
	Examin	er	a. Facility Name (If not institution, give street and numb	er) SPITAL		4b. City, Town, or FREDER				EDERIC	K		
	Financi			Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthpl	ace (State or	Foreign	
	Funeral Director		1□ M 2☑F	84	Yrs.	Months Days	Hours Min.	AUG.13		Count WEST	MINSTE	ER,MD	
	P .		Usual Residence of Decedent 10a, State 10b, County	10c. City, Toy	wn or Loc	ation				10	d. Inside Cit	y Limits	
	anylaı show	'n									1 □Yes		
	the M 28a-f notifie	Director	MD FREDERICK 10e. Street and Number	EMMIT	SBUR	G 10f. Zip Code		1	0g. Citizen o	of What Count	ry?		
	3a or		17109 RIFFLE RD.			21727			U.S.	Α.			
	death	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S. es?	13. W	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		Race - America Black, White, e			
936	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Dat	ŊNo		□Yes 2⊠No	Specify:		Spe	.,	ITE		
15-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16	a. Deced	ent's Usual Occupa kind of work done of O NOT use retired	ation Juring most of work	king	16b. Kind of	Business/Ind	ustry		
2	nthin ne.	mple	Elementary/Secondary (0-12) College (1-	lor 5+))						
2	be filed w ntal Hygie of other t event, th		6 17. Father's Name (<i>First, Middle, Last</i>)		H	OMEMAKER	18. Mother's Nam	e (First, Middle, I		HOME name)			
Maryland	be eve	To Be	HARRY 1	USBAUM				ELIZAE	BETH E	YLER			
<u></u>	should be and Menta s marked umatic ev	F	19a. Informant's Name/Relationship (Type. Print)	15	9b. Mailin	g Address (Street a	and Number or Ru	ral Route Number	r, City or Tov	vn, State, Zip	Code)		
	nd 2 alf h 27 is rtra		DENNIS ANDREW/SON			9 RIFFLE							
altimore,	ges 1 a t of Hea If item or othe		20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S	20b. Place ceme	of Dispos tery, crem	sition (Name of natory or other plac	e) :	Date	20c. Locatio	on - City or To	wn, State		
Ĕ	Pa men ant: ury		4 □ Domation 5 □ Other (Specify)	SMIT		RG CREMAT				SBURG,	MD.		
Bal	permit. Page Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	?	22	Name and Addres	MAIN ST.,	SKILES E			727-04	27	
5.			23a. P / 1. Enter the disease, or complications that ca h / ck, or heart failure. List only one cause on ea	used the death. D	o not ente					- ZI	Approximate Interval Bet		
	Physician	11/8	Immediate Cause (Final	ch line.	1	Centia	Vananta	- Delia	ane.		Onset and I	Death	
	/Medical		dis-as- or condition resulting in death)	r as s consequenc	ce of):	Carkio	in contract	() 003tm			170		
	Examiner		Sequentially list conditions b. A CA			dong	setur	/			10 dry	2_	
7	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	r as a consequenc	og of):	/				1	/		
34	tificate be executed g physician and as the burial-transit	Examiner	that initiated events c										
68760,	e be e sician burik	cal E	d.										
_		ledical					17		Ī				
Box	eath cert attending	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the cast 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23d. Month Day Ye										
о П	ie dea the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	int at time of death wn	n 5	Other (specify) _					,		
Division or Vital Records, P.O.	luires that the de n signed by the a lid be detached f	Phy	Part II. Other significant conditions contributing to de	ath but not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use o	contribute to the	ne cause of c	leath?	
ds,	uires signe Id be	d by						1 □ Y	es 2 N	o 3□ Prob	ably 4 🔲	Jnknown	
CO	w req	Completed						24a. Was a	an 2	4b. Were auto	psy findings	available	
æ	The la te has age 2	dwo						autop perfoi 1☐ Yes	rmęd? 2 V No	death? 1 ☐ Yes	mpletion of c	ause oi	
ţa	ian: rtifica tor, p	Be C	25. Was case referred to medical				26. Place of Dea	ath Check onl of			/		
<u>-</u>	hysic his ce I direc	To E				t 3□ DOA Oth	4 🗆 Nursing F	lome 5 Resid			<i>(y)</i>		
n o	ing P	:uo	1 Alvatural 5 Trending	f Injury 28 n, <i>Day Year)</i>	b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe h	now injury oc	curred			
Sio	death ctor: /	icati	Accident investigation 3 Suicide 6 Could not be 28e. Place	of injury - At home	, farm, str		7es 2 140	28f. Location (S		umber or Rur	al Route Nun	nber,	
<u></u>	after Direction by	Certification:	4 Homicide determined building	ig, etc. (Specify)				City or Tow	vn, State)				
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	best of my knowled asis of examination er stated.	dge, deat and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)	
	o the vithin ;	Mec	29b. Signature and interof certifier))	29c. Licens	se number		29d. Date of	gned (Month,	Day, Year)		
)	FSFO		> Xshill Harls	ran		D-	1397		5//	3/0	7		
7	a		30. Name and address of person who completed caus	e of death (Item 23	Ba) (Type,	Print)	/		1	1			
	3		ROBERT L. KAUFMANN, N	1.D., 300	W.	9 TH STRE	EET, FRED	ERICK, M	ID. 21	701			
	St Regist	ate	31. Date filed (Month, Day, Year) 32 R	egistrar's Signature	An	Call 3							
	ricgis	Tell .	WISAL T COOL JULY	Total Marie and and	1	- Black							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30 -TON City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Frincess ANNE If Under 1 Year | If Under 24 Hrs. | 8 | ioch nue Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 225-66-9726 56 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Somerse 10g. Citizen of What Country? Venue 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Newport News Elementary/Secondary (0-12) College (1-4or 5+) FIRST CLASS WELDER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md 21852 30180 antioch Cassandra Urmstrong (wife) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BENNIE Smith 917 W. ISAbella Street I Funeral Service Licenses SALISHURY, md 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Carise (Final disease or condition resulting in death) a. Metastatic Lum Canal. FUNERAL Home Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 Probably 4 ☐Unknown 24a. Was an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

or Itams 23a

"natural",

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Imperant: If tem 27 is marked other than "ne any in ury or other traumatic averagence."

Director

Funerai

Be Completed by

other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit ίο icate has been sig , page 2 should b wi hin 24 hours after death. To the Funeral Diractor: the

P.O. Box 68760

Division of Vital Records,

Physician/Medicai Examiner Be Completed by Medical Certification: To

IF FEMALE:

25. Was case referred to medical examiner?

1 ☐ Yes 🛂 No

27. Manner of eath

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

performed? (es 2 Z No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Other: 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatule and title of certifier

30. Name and addre of person who completed cause of death (Item 23a) Type, Print)

5 Pending

investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

filled in by

pcmpletely

==

31. Date filed (Month, Day, -Year) 03

OLLU

32 Registrar's Signature

Hospital: 2 ER/Outpatient

3□ DOA

DHMH 17 Rev 1/2001

ORIGINAL

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		•	For State Registrar	State of Mary			nt of Heal te of Dea			jiene eg. No.	107	16025
l,	Physici	an	Decedent's Name (First, Middle, Last)						Date of Dea Month	Day	Year	3. Time of Death
	/Medic	cal	ANNA CHRISTIN			4h Cin	, Town, or Loca	ation of Dooth	MAY 8	2007	ty of Death	9:40P M
	Examin	ıer	4a. Facility Name (If not institution, give str CHARLES CO.NU		D CENTE			PLATA			RLES	
10.3	Funeral		5. Social Security Number 6. Sex	7. Age (II	n yrs. last birthday)	If Unde	er 1 Year If U	Inder 24 Hrs.	8. Date of Birth (Month, Day			place (State or Foreign ntry)
e de	Director		229-24-8388 ¹⁰	vi 2 🔭	80 Yrs.	Months	Days Ho	iurs Min.	3-26-1	927	VA.	y
700	2 3		Usual Residence of Decedent 10a, State 10b, County	10	oc. City, Town or Lo	cation					1	10d. fnside City Limits
200	faho	ō	MD. CHARLE				PLATA					TY Yes 2 No
94	7 28a-	Director	10e. Street and Number			10f. Z	ip Code		1	0g. Citizen o	f What Cour	ntry?
£	238.0	aD	10200 LA PLAT	'A ROAD			20646	6		U.S.	Α.	
-0036 hours after death with the Mandaod	lems ermi	Funeral	11. Marital Status	2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Dec	edent of Hispani ecify Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americack, White,	
36	or i	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No ff Yes, Give Year or Dates:		1 🗌 Yeş	2 No Spi	ecify:		Spec	ify:	WHITE
215-0036	atura	ed	15. Decedent's Educa	ation	16a. Deced	dent's Us	ual Occupation			16b. Kind of	Business/In	ndustry
:1215 -21515	March n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) Coflege (1-4or 5+)	(Give	kind of w DO NOT	rork done during use retired)	most of worki	ng			
2	Hygien ther th	Con	11th		H	MEMC	IAKER			OWN		
	od oth	Be	17. Father's Name (First, Middle, Last)				18. 1		(First, Middle, MAE T		ame)	
Maryland	of any 2 should be greater within 22 hours site destiting the wayful Health and Mental Hygiene. Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Exembras must be notified at	2	OTTAWA WOLFE 19a. Informant's Name/Relationship (Type	a Print)	19b Mailir	ng Addre	ss (Street and N		I Route Number		n State. Zir	2 Code)
E S	ith ar 27 is 27 is		DONNA NORRIS-D	,			ON DR.		RELL,T			,
re,	Item othe	Εĝ	20a. Method of Disposition		20b. Place of Dispo	sition (N	ame of		Date	20c. Location	n - City or To	own, State
mor	nent of ant: # It		¶ Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State	MD.VETS			5-15	-07 C	HELTE	NHAM	,MD.
Baltimore,	Department of the property of		21. Signature of Funeral Service Licensee		(D	$\mathbf{A} \mathbf{V} \mathbf{M} \mathbf{C}$	and Address of FUND FUN	ME'RAI.	SERVIC	E,P.A	•	
武装	* *		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the	death. Do not ent	er the mo	ATA, MI ode of dying, suc	ch as cardiac of	46 or respiratory arr	est,		Approximate Interval Between
P	hysician		fmmediate Cause (Final disease or condition	Conc			Hea	ct	Fa:	lure	0	Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of):	-	1100	(1)		/_0(1		
4	xaminer	U	Sequentially list conditions, b.	COP	0							
\$.5	nsit	ulner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):							
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18760, C	ysicial e buri	dlcal	d.									
		Medi	VE EELIAL E									
Box 6	attending J	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of p		Ectopic	pregnancy				Date of deliver	ery Day Year
	, 6 2	slci	1 Tyes 2 No	4☐Pregnant at tim 9☐Unknown	e of death 5	Other (specify)				nontri	Day 16a1
ع و	igned by be detac	F.	Part II. Other significant conditions conti	nbuting to death but n	ot resulting in the u	nderlying	cause given in I	Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?
ecords,	sign ed bl	d by				, ,	,		1 □ Y	es 2□No	3 🗌 Prot	bably 4 V Unknown
OS S	s been si	lete					•		24a. Was a	ın 24t	. Were auto	opsy findings available
T g	nis certificate has b	Completed							autops perfor	med? 2 A No	prior to co death? 1 \sum Yes	empletion of cause of
E	ortifica ctor, p	Bec	25. Was case referred to medical				26.	Place of Death	(Check only or		100	
> 1	this ce al dire	70	examiner? 1 Tes 2 No		2 ER/Outpatier	nt 3□ [Nursing Ho	me 5 Resid	ence 6 🗆 C	ther (Specif	fy)
Division of Vital	After th		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time of Injury		28c. Injury at Work?		28d. Describe h	ow injury occ	urred	
VISION OF VITA	er death rector: A by the fi	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Pface of Injury	- At home form etc	M	1 Tes		28f Location /S	treet and Nur	nher or Run	al Route Number,
	after Direct d in by	Certification:	4 Homicide determined	building, etc. (Specify)	eer, rack	ny, othos		City or Tow		nbor or riare	arrioble ivalider,
]	within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifying Physic (Check only one)	cian: To the best of m er: On the basis of ex and manner stated	amination and/or in	h occurre vestigatio	d at the time, da	ate and place, n, death occurr	and due to the cred at the time, c	ause(s) and a late and place	manner as s e, and due t	stated. o the cause(s)
4	omple	₩ We	29b. Signature and title of certifier	and manner stated		2	9c. License num	nber	2	9d. Date sign	ned (Month,	Day, Year)
•	- > - 0		> 4.1Aloun		$M\Omega$		055	455		51	19/0	07
	ì		30. Name and address of person who com	pleted cause of deat	h (ftem 23a) (Type,	Print)		,) -				
	Q		FATIMA HUS	SEIN								
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 2007	32 Registrar's	Signature	we see						

To concentral facility (Control of Parank M. Babula Santa and service and				For amend#3 State RegistrarAACO	Health 1	/• Decertment	f Maryland OMH 5/1/0	_	artmen rtificat			and M	R	eg. No:	07	16028
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Total Continue Tota				4a. Facility Name (If r Fairhave	ot institution, g n Healt	ive street and nu h Center	mber)		4b. City,	Town, or Syke	svil.	le		C	arrol	
The part of the pa	** TR:											Min.	8. Date of Birth (Month, Day NOV • 21	Year) 1914	9. Birthp Cour Ne	place (State or Foreign htry) W York
Secretary states Figure March Figure F		p ,					10c City	Town or Lo	cation						1	10d, Inside City Limits
Secretary states Figure March Figure F		aryla ehov	č			roll										1 ☐ Yes 2X No
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Segmentally let conditions as a consequence of): Constitution	-15			shock, or heart mediate ause (F disease or ondition	failure. List or	ly ogle cause on	each line.	. Do not en	ter the mod	de of dyin	g, such as	cardiac c	or respiratory ar			Interval Between
FFEMALE: 23d Date of delivery 23d Da	,60,	Examiner		Sequentially list conditions, leading to implicate the cause (Disease or in that initiated events	nediate ying ijury	b. Due to	(or as a consequ	ence of):		1						-
State Stat	Box 6	ne death certificate the attending phys thed for use as the	ysician/Medic	23b. Was decedent in the past 12 n 1 \(\superscript{Yes}\) 2 \(\superscript{\superscript{1}}\)	nonths?	1☐Live 4⊡Preg	birth 2 ☐ Fetal nant at time of de	death 3								*
State Stat	Δ.	signed by	d by Ph	Part II. Other signific	cant condition	s contributing to	death but not resu	ulting in the	underlying	cause giv	en in Part	l.		_		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and the of certifier one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) April 19b. Matthoop 19 Ridge Road Washington (Type, Print) 31. Date filled (Month, Day, Year) 32. Resistrar's Signature	Recor	e la has	Complete							· - · -			autop perfo	rmed?	prior to codeath?	ompletion of cause of
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29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACTUAL MAHMOOD 19 RICHE ROCAL Washington. 31. Date filled (Month, Day, Year) 32. Registrar's Signature	Divisio	or Attend after death Director: , in by the f	ertificat	3 Suicide	6 Could no	t be 28e. Place	ee of Injury - At ho ding, etc. (Specify	ome, farm, s			165 2				mber or Ru	ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TABLE MAHMOOD 19 Riche Road Washminster MD 24257 State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature	J	Hospital 24 hours a Funaral		(Check only	ft∰ Certifying 2 ☐ Medical E	xaminer: On the	basis of examinat	wledge, dea tion and/or i	th occurred	at the tin	ne, date a pinion, de	nd place, ath occuri	and due to the red at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TABLE MAHMOOD 19 Riche Read Westminster MD 24:257 State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature		o the o the omple	Me	29b. Signature and	Ne of certifier				29	c. Licens	e number			29d. Date sig	ned (Month	n, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIC MAHMOOD 19 Riche Road Washminster MD 21157 State 31. Date filed (Month, Day, Year) 32. Resistrar's Signature		ŏ⊣≵⊣		1	m-				1)43	372	ć		4/2:	3/07	
State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature		20.01		and the same of th	A	Α.	0 0 .	Y)	, Print)	W	estu	nini	Her	MD	211	57 O
				31. Date filed (Mont	n, Day, Year)	32.			1	<i>y</i> .				-	211	57 9

			1 - For State Registrar	State of Mary	•	artment of F rtificate of		, ,	giene Reg. No. 🤈 🗎	0.7	16029
75	Physici /Medic		1. Decedent's Name (First, Middle, Las Beulah	Viola		Burge	ss	2. Date of Dea Month April 2	Day	Year	3. Time of Death 7:25 AM ^M
) ==	Examin Funeral Director		4a. Facility Name (If not institution, give 3675 Solomon Isla 5. Social Security Number 6. S 220–20–2403	and Road	yrs. last birthday) 7 Yrs.	4b. City, Town, o Harwoc If Under 1 Year Months Days			4c. County Anne h, Year) 929	Arunc 9. Birthp Coun	le1 lace (State or Foreign try) r1and
	D	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Arur	10	c. City, Town or Lo Severna 1			00/12/1			0d. Inside City Limits 1 □Yes 2 🛣No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 870 Cottonwood Ro	oad		10f. Zip Code 21146	-		10g. Citizen of V	try?	
2-nn-c	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No		pecify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americ k, White,	
0-C1717	filed within 72 ho Hygiene. ther than "natur ent, the Medical I	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ide completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire iatric Ai	during most of wo	rking	16b. Kind of Bu		lustry
aua ,	d be filed antal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) Leroy	I.	Lacer		18. Mother's Nar Sophia	me (First, Middle,	_	onawa	ıv
Mary	and 2 should be filed wealth and Mental Hygie n 27 is marked other ther ter traumatic event, th	ပ	19a. Informant's Name/Relationship (Beulah Iafolla		19b. Mailir	ng Address (Street Janice A	and Number or R	ural Route Numbe	er, City or Town,		
salumore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	Nob. Place of Dispo Metro Cre	matory or other pla ematory		-,	20c. Location - Baltimo	ré	MD
Dall	permit. Page Department of Important: If any Injury or		21. Signature of Fundal S. rvice Licer	asee	Ha	2. Name and Addre ardesty F	ss of Facility uneral H Gambri	ome P.A. Nary	1851 An 1and 21	054 ⁰¹	is Road.
)	Physician /Medical Examiner	ier	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reguing to immediate	a. Due to (or as a co	Insequence of):	L /	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
00/00	fficate be executed g physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	c	insequence of):						
O. Box o	certi iding se a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			te of delive	ery Day Year
records, r	6 6 0	Completed by P	Part II. Other significant conditions of	. 4	ot resulting in the u	nderlying cause giv	ven in Part I.	1 ☐ \ 24a. Was a	res 2 □ No an 24b.	3 ☐ Prob	ne cause of death? hably 4 AUNknown psy findings available impletion of cause of
VIII	r sician : The law s certificate has E lirector, page 2 s	Be Col	25. Was case referred to medical examiner?				26. Place of De		2 X No		2 No
sion or v	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	၉	1 Yes 2 TNo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o	f 28c. Inju		Home 5 Resid	dence 6 Soth		Assited Lwg
DIVISI	ital or Atten rs after deal al Director led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	and the same of		reet, factory, office		28f. Location (S City or Tox		er or Rura	d Route Number,
	To the Hospital or within 24 hours after Formeral Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2/ Medical Exam	nysician: To the best of m miner: On the basis of exa and manner stated	amination and/or in	h occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)
	within com	N N	29b. Signature and title of certifier	MD			se number		29d. Date signe 4/27	d (Month,	Day, Year)
	Sta	ite_	30. Name and address of person who Da Left Singh 31. Date filed (Month, Day, Year)	Sidny 208 32. Refistrar's	Crain t		SW Gl	en Buss	nie M	D21	061
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			For State	State of N	/larylan		artment r <i>tificate</i>			and M	ental Hy	•	er er er	1.6	0.00
			Registrar 1. Decedent's Name (First, Middle, L	ast)			imouto	0, 2	Calli	Т	2. Date of De	Reg. No	0.	3. Time of	Death
98	Physicia /Medic		Carroll R. Brun	dred						1	Month May 1,	200	ay Year 7	5:05	РМ
	Examin		4a. Facility Name (If not institution, g		er)		4b. City, To	own, or	Location o				c. County of Death	1 5 1 5 5	
	··		Shady Grove Adve				Rocky		.e			M	ontgomery	7	
Ĭ	Funeral Director		5. Social Security Number 565–32–2674 6.	Sex 7.7 1 □ M 2 🛣 F	Age (în yrs. î 81		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D 03/17	ay, Year	r) Cour	place (State ontry)	r Foreign
	pu ,		Usual Residence of Decedent	•	100 0:4	, Town or Lo									
	show	'n	Maryland Montgom	erv	_ '	omac	cation						1	10d. Inside Ci 1X1Yes	-
	the M	Director	10e. Street and Number				10f 7in 0	ode				10- 0	idinan of 18th at Court		
	with 3a or 1 be r		10805 Fox Hunt L	ane			10f. Zip 0	54					itizen of What Cour ted State		
	ms 2:	Funeral	11. Marital Status	12. Was Deceder		S. 13.	Was Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)		14. Race - Americ		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ② If Yes, Give Year or Dates	No No		lf Yes, specif 1 □ Yes 2		i, Mexican Specity:	i, Puèrto i	Rićan, etc.)		Black, White, Specify: Whit		
Š	2 hou atura ical E	ted	15. Decedent's	Education		16a. Dece	dent's Usual	Occupa	tion			16b. i	Kind of Business/In	dustry	
215	thin 7 e. an "n Medi	Completed	(Specify only highest g	College (1-4o	r 5+)	(Give life.	kind of work DO NOT use	done di retired)	uring most	t of workir	ng				
2	ygien ygien er th t, the	5		4		Homen	aker						n Home		
nd	be file d oth d oth even	Be	17. Father's Name (First, Middle, Las	st)							(First, Middle	, Maide	n Surname)		
3	d Mer narke	은	Carroll Ridgway 19a. Informant's Name/Relationship	(Toron Drine)		405 84-77				ma Kı					
Maryland 21215-0036	nd 2 si alth an 27 is r ir traur		Benjamin F. Brun		/ Son								or Town, State, Zip		
Jre,	ss 1 a		20a. Method of Disposition			lace of Dispo emetery, crei	sition (Name	of er place	2)	D	ate	20c. L	ocation - City or To	own, State	
Ē	Page nent c ant: If any or		1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		te	ional	-			5/03,	/2007	Fal	ls Church	, Virg	ginia
Baltimore,	epartr epartr nporta ny Inju		21. Signature of Funeral Service Lic	ensee									r's Sons		
_	<u>00 = 60</u>		w. arg M	lencer									gton, DC		
L			23a. Part1. Enter the disease, or co shock, or heart failure. List on									arrest,		Approximate Interval Bet Onset and I	ween
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Chronic			re Pulr	nona	ry D	iseas	se		5	Onset and I	3
	Examiner			Due to (or a	as a consequ	uence of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequ	uence of):									
	ecuted nd transit	Examiner	triat iritiated events	c											
8760,	cate be executed physician and the burial-transit	E	resulting in death) Last	Due to (or a	as a consequ	sence of):									
387	physic	dical		d											
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne pf pregna	псу							23d. Date of delive	on.	
m̈́.	death e atte	iciai	in the past 12 months?	1 □Live birth 4□Pregnant	at time of de		Ectopic preg Other <i>(sp</i> ec						Month	-	Y ear
P.0.	at the by the tache	hys	9 Unknown	9∐Unknown							T				
or Vital Records, I	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions	contributing to death	but not resu	ılting in the u	nderlying cau	se give	n in Part I.				use contribute to to		
000	s beer shou	lete									24a. Was	an	24b. Were auto	nev findinge	availahle
Be	The la	Completed									auto perf	psy ormed?	prior to co death?	mpletion of ca	
ţa	ian: rtifica stor, p	Be C	25. Was case referred to medical						26. Place	of Death	1□ Yes (Check only	2 ⊠ N one)	o 1 □Yes	2□ No	
<u>-</u>	Physician: r this certificanal director,	ToE	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1XXnpa	itient 2 🗆 I	ER/Outpatier	it 3□ DOA	Other	r: 4 🗆 Nui	rsing Hor	ne 5□Res	idence	6 □Other (Specif	'y)	
0 0	Ing P		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury	280	. Injury Work	at ?	2	8d. Describe	how inju	ury occurred		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigati 3 Suicide 6 Could not	ho			М		es 2□ñ						
Division	after after Direction by	Certification:	4 ☐ Homicide determine	d 28e. Place of i building,	etc. (Specify	me, rarm, str	eet, factory, o	onice		2	City or To		and Number or Rura te)	al Route Num	iber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier	Physician: To the bes	st of my know	wledge, deat	occurred at	the time	e, date an	d place, a	and due to the	cause(s) and manner as s	tated.	
	he Ho in 24 i he Fu pletel	Medical	(Check only 2 ☐ Medical Ex- one)	aminer: On the basis and manner:	of examinat	tion and/or in	vestigation, in	n my op	inion, dea	th occurr	ed at the time	, date ai	nd place, and due to	o the cause(s	5)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	/ ,			1	icense	number				ate signed (Month, 1, 2007	Day, Year)	
	(0		Cort H. A	pourby	1 /	UD'		JJ40				riay	1, 2007		
	4		30. Name and address of person wh Carl Schoenberge					aith	ersb	urg.	MD 208	377			
	Sta	ite	31. Date filed (Month, Day, Year)	32 Regis	strar's Signat	ture				,					
	Registr	ar	MAY 03 2	JU/	w D	April 1	See !								

Amended Item 26 per Physician 05/03/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State (of Maryland / [nent of He cate of D			ene 00	7 603
			. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia	_	Patricia June Brad	i7				April	30 200	9:00a ^M
	/Medic		a. Facility Name (If not institution, give street and n		4b.	City, Town, or	Location of Death		4c. County of [
	Examin	er	1280 Sellmar Road	,		Kitzr	miller		Gar	rett
	5		i. Social Security Number 6. Sex	7. Age (In yrs. last bir		Jnder 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Funeral Director		275-32-3662 1□M 2€F	70	Yrs. Mo	nths Days	Hours Min.	Mar 18	1937	MD
			Jsual Residence of Decedent	70				1101 10		
	fand		Oa. State 10b. County	10c. City, Tow	n or Locatio	n				10d. Inside City Limits
	Mary if sh	ğ	MD Garrett	K.	tzmi]	lor				1 XYes 2 ☐ No
	the 28a	Director	10e. Street and Number	N.L		of. Zip Code		10	g. Citizen of Wha	at Country?
	with a or		Race Street			2	1538		USA	
	eath	Funeral		cedent Ever in U.S.	13, Was		spanic Origin? (Spo n, Mexican, Puerto	cify Yes or No-	14. Race -	American Indian,
	iten Iten	5	Amed	Forces?			n, Mexican, Puerto	Rican, etc.)	Black, \	White, etc.
9	irs af		3 ☐ Widowed 4 ☐ Divorced Year or	aive evic	10	res 2√x No	Specify:		Specify:	White
ŏ	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show ha Madical Examinar must be notified at	Completed by	15. Decedent's Education		. Decedent	S Usual Occupa	tion		6b. Kind of Busin	ness/Industry
2	n n	ple	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	lite. DO N	of work done d IOT use retired)	uring most of work	ng		
2	tha iene	mo	10	(1-401 37)	Ins	pector		В	ausch a	and Lomb
O	e filed within al Hygiene. I other than '	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	faiden Sumame)	
Maryland 21215-0036	2 should be and Mental is marked o	To B	Eldred Sterling Bur	ng			Vir	ginia B	arrick	,
<u> </u>	should and Men marke umaric	1-	19a. Informant's Name/Relationship (Type, Print)	198	b. Mailing Ad	idress (Street a	nd Number or Run	al Route Number,	City or Town, Sta	ate, Zip Code)
S	id 2 ith ar ith ar itrau		Doug Brady/son		1280	Sellma	ar Rd K	itzmill	er, MD	21538
á,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 the Wath and Mental Hygiene 1 them 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition	20b. Place of	of Disposition	n (Name of ry or other place	5/0	3720072	loc. Location - Cit	ty or Town, State
altimore,	nt of nt of nt of :: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	II State			´ ! :			
₽	t. P.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Carr			ion, In			ead, MD
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Fullerial Service Courses	1			uneral			
	40244		23a. Part1. Enter the disease, or complications that	S days doub Do	41:	2 Wash	ington	Rd West	minste:	MD21157 Approximate
			shock, or heart failure. List only one cause or	each line.	HOL BIILDI III	e mode or dying	y, such as cardiac	7 Teaphatory arro	31,	Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition ameta	static lu	ing c	ancer,	squamo	us cel.	1	15 months
	/Medical		resulting in death) Due t	o (or as a consequence	of):					
	Examiner		Sequentially list conditions. b							
	P =	ner	cause. Enter Underlying	o (or as a consequence	of):					
	cute	Examin	Cause (Disease or injury that initiated events c.							
Ó,	death certificate be executed e attending physician and of for use as the burial-transit	Ë	resulting in death) Last Due I	o (or as a consequence	a of):					
8760,	physici physici the bu	edical	d							
9	tifica ng ph as th	Med	le reture							
Вох	eath certifi attending	Physician/M	23b. Was decedent pregnant	outcome of pregnancy birth 2 Detail deat	h 3∏Ed	opic pregnancy			23d. Date of	
ω.	deati e attr	lcia	in the past 12 months?	gnant at time of death		ner (specity)			Month	n Day Year
Ö	by the datached	hys	9 □Unknown 9□Un	known				1		
σ.	s tha	by P	Part II. Other significant conditions contributing to	death but not resulting	in the under	lying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
g	quires n sign ald be							1 X Ye	s 2□No 3	☐ Probably 4 ☐ Unknown
Records,	The law requires that the tee bas been signed by the bage 2 should be detache	Completed						24a. Was a	n 24b. We	ere autopsy findings available
Re	The lav	E G						autops	ned? dea	or to completion of cause of ath?] Yes 2 □ No
a	10						an Plans of Door	1 Yes 2	22	Yes 2 No Son's
Viital	Physician: this certific al director,	Be	25. Was case referred to medical examiner? Hospital:			Othe		h (Check only on		(Specify)Residence
ot	Phys this	2	1 Tes 5 Muo	☐ Inpatient 2 ☐ ER/C te of Injury 28b.	Outpatient : Time of	****		28d. Describe ho		
		on	1 XNatural 5 ☐ Pending (M		Injury	28c. Injun Worl	(? Yes 2 □ No	200. 0 000.00	,,	
Sic	ten leati tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e Pla				. 63 2	28f Location (St	reet and Number	or Rural Route Number,
Division	or Attendated after death	E	determined 200. Flo	ice of Injury - At home, filding, etc. <i>(Specify)</i>	rarm, street,	factory, office		City or Town		or rigidity to did the transfer
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by						1	and distant		nor an stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physician: To 2 Medical Examiner: On the	e basis of examination a	ge, death oc and/or invest	curred at the tin igation, in my o	ne, date and place, pinion, death occui	and due to the ca red at the time, da	ause(s) and manr ate and place, an	d due to the cause(s)
	the hin 2. the L	led	one) and m	anner stated.						'Month, Day, Year)
	Viit Com	2	29b. Signature and title of certifier	110		29c. License			96. Date signed (
	WJL		1-brace / Tu	March	94 .	D300	,,,,		0 0 - 0 1 - 2	2007
	Wiz		30. Name and address of person who completed c							
	ı			M.D. 1533	3 Mem	orial	Drive (akland	, MD 2	1550
	St	ate		. Registrar's Signature						
	Regist	rar	MAY 0 3 2007	Mereva &	K A	make 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2007 April 02:10 P M Jacqueline Dawn Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 1000 Sextant Court Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/20/1944 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 K 63 Pennsylvania 186-34-1184 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 1000 Sextant Court 21401 United States Pages 1 and 2 should be filed within 72 hours after death vert of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturat", or items 23s mis; If item thaumatic event, th. Medical Examiner must iny or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Manager Collectables Stores 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jack Donald Kurtz Gloria J. Heller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important; If Item 27 any injury or other troope, Donald W. Brown II/Husband 1000 Sextant Court, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Kalas Crematory 05/01/2007 Edgewater, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death melastatu Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as nsequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of certificate has brieflector, page 2 s perform death? 1 🗆 Yes 2 □ No 1□ Yes 2☑No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Vithin 24 hours after To the Funeral Director To the F Hospital

Medical State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 75

(Check only

29b. Signature and title of certifier

29a. Certifier

31. Date filed (Month, Day, Year) MAY 0 2 2007 32. Paistrar's Signature

1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Rd Ste 300 Annapolis mo

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 4/28/2007 **Physician** Mary Caroline Bernstein 2:20 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbor Nursing Home Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/11/1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 □ M 2 🕏 F 75 216-30-6723 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County ns 23a or 28a-f show must be notified at 10d Inside City Limits Director 1 ☐ Yes 2X No Anne Arundel Gambrills MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 USA 965 St. Stephens Church Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify. δ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lien Clerk State of MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles George Bernstein Elizabeth Gantt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 965 St. Stephens Church Rd. Gambrills, MD 21054 Charles W. Bernstein Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 5/4/2007 4 Donation 5 Other (Specify) Cedar Bluff Cemetery Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licen Datad 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of). Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 □Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☑ No Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copribute to the cause of death? ģ Completed 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No After this certificate has autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes Other: 2 ER/Outpatient 1 | Inpatient 3□ DOA 4 Designed 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending 1 TYes 2 TNo

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, death.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: Certification: To investigation after death Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

leted cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of person who com

0 2 2007

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and

1

Director

Funeral

Be Completed by

ဂ္

Examiner

Physician/Medical

Completed by

Certification: To Be

Medical

Physician

/Medical

Examiner

Funeral

= State Registrar			of Maryla					Death			Reg. No	000	17	16035
. Decedent's Nam	e (First, Middle, Keith Ca	,		,						2. Date of Month	Death Da	y Y	ear	3. Time of Death
										4/	26/20			1312 M
a. Facility Name (mber)		4	4b. City,	Fown, or	Location	of Death		40	. County of	Death	
	llins Av						ento		- 04 I lun			ine Ar		
Social Security I		. Sex 1 <mark>X</mark> M 2□ F	7. Age (In y	rs. last birthd 57 Yrs	~"/	If Under Months	Days	Hours	r 24 Hrs. Min.		Day, Year,	1	Countr	
218-52-3				57 Yrs	<u></u>					11/12	/1949		wes	t Virgini
0a. State	10b. County		10c.	City, Town or	r Loca	ition							100	d. Inside City Limits
MD	Anne A	runde1	0	denton	1									1 ☐ Yes 2X No
0e. Street and Nu	mber					10f. Zip	Code				10g. Ci	tizen of Wha	at Countr	y?
261 Col	ins Ave					· ·		113				USA		
1. Marital Status	LIIIO AVE	12. Was Dec	edent Ever in	U.S. 1	13. Wa	as Deced			rigin? (Sn	ecify Yes or	No- T	14. Race -		n Indian,
	ried XXMarried	Armed Fo	orces? 2 ⊠ No							ecify Yes or Rican, etc.)		Black,	White, et	C.
3 ☐ Widowed		If Yes, Gi Year or D	ive		1 [□Yes 2	EA-No	Specify	<i>':</i>			Specify:	wnit	e
	15. Decedent's	Education				nt's Usua					16b. K	ind of Busir	ness/Indu	stry
(Spe	cify only highest	grade completed) College (- (G life	iive kii fe. DC	nd of wor NOT us	k done d e retired	during mo l)	st of work	ring				
	1.2	Conege (1- 4 01 J+)		L	umbe	r Ja	.ck				Loggi	ng	
7. Father's Name	(First, Middle, La	ıst)		•				18. Moth	ner's Name	e (First, Midd				
John Flo	oyd Carr							R	uby (Carlis	le Bu	rns		
9a. Informant's N eslie J	ame/Relationship Carr	(Type. Print) Son		I	_	_				al Route Nur Burni				Code)
0a. Method of Dis	position		20t	. Place of Di	isnosit	ion (Nam	e of	- 1		Date	-	ocation - Ci		n, State
		Removal from		cemetery, o		_ `		1	1. /20	/2007	- د ۸	n t c	MD	
21. Signature of F	5 ☐ Other (<i>Spe</i> uneral S ervice La		6	piphan 						/2007 rdesty		nton,		D 4
1 18	- 1. (rdesty napoli				r.A.
23a. Part1. Enter	the disease, or co	omplications that	caused the de	eath. Do not						_		, 2140	5. 1	Approximate
shock, or he mmediate Cause	art failure. List or	ily one cause in	each line.			,		+1	0	1		. 17 194 154 .		nterval Between Onset and Death
disease or condition resulting in death)	on	a. ftr		0501	Er	0110		11	LIN	4 1)15	1175	w(
3	-	Due to	(or as a cons	equence of):										
Sequentially list co	onditions,	b	fur we a cone	annanes of	-									
any, leading to li ause. Enter Und Cause (Disease o	erlying	Due to	(บา ล้อ ลี ฉับก็อ	equence of).										
hat initiated event esulting in death)	S	C. Due to	(or as a cons	edilence of										
,		Due 10	(or as a cons	oquence of).										
		d											-	
F FEMALE:		00 - 11										-		
23b. Was deceder in the past 12			birth 2 ☐ F	etal death		ctopic pre		,				23d. Date of Month		/ Day Year
1 ☐ Yes 2	□No	4□Preg 9□Unkr	nant at time o	of death	5 🗆 C	Other (spe	ecify)				-	WOULT		, teal
9 Unknow														
art II. Other sign	ficant condition	s contributing to d	leath but not r	esulting in the	e und	erlying ca	use giv	en in Part	I.					cause of death?
										1 [Yes 2	□ No 3	☐ Proba	bly 4 □Unknown
										24a. W		24b. We	re autops	sy findings available pletion of cause of
							<u> </u>			pe	rformed?	dea	ath?	
5. Was case refe	rred to medical							26 Dica	on of Doct	1 Ye:		1 1 1	Yes 2	! ∐ N0
examiner?		Hospital:	Inpatient 2	☐ ER/Outpa	tiant	3□ DO	Δ Oth	or:		h (Check onl		6 DO#=	(One -16)	
7. Manner of Dea		28a. Date		28b. Tim				401		ome 5 Re 28d. Describ				
1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigat 6 ☐ Could no	tion	nth, Day Year) Injui	ry	М	Bc. Injur Worl 1 □	k? Yes 2 ⊑						
3 ☐ Suicide														

The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran To the Hospital or Attending Physician: within 24 hours after death.

Physician /Medical

> 25. Was case examiner? 27. Manner of 1 Natura 2 Accide 3 ☐ Suicid 4 Homicide determined building, etc. (Specify) City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> > 29c. License number

95 America

29d. Date signed (Month, Day, Year)

21035

State Registrar

ONES 31. Date filed (Month, Day, (0 1 2007

32. Registrar's Signature

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Joseph Walter Carter, Sr. 9:35 P M 2007 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 40425 Kavanagh Road St. Mary's Mechanicsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1፟**X**M 2□F 94 Yrs Director 219-32-2004 April 9, 1913 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland St. Mary's Director Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 40425 Kavanagh Road 20659 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 N Married ō 1 ☐ Yes 2K No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Apartment Building Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Henry Carter Annie Sophie Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Genevieve Carter / Wife 40425 Kavanagh Road Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State May 11, 2007 Sacred Heart Cemetery Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licerisee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Inst only one cause on each line. Approximate Interval Between Heart Immediate Cause (Final disease or condition resulting in death) **Physician** Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2□ No 1 Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatio

/Medical Examiner Division or Vital Records, P.O. Box 68760,

Baltimore. Maryland 21215-0036

Certification:

25. Was case referred to medical	T
examiner? 1 ☐ Yes 2 ☐ No	
27. Manner of Death	Ċ

ent	2 ER/Outpatient	3□ DOA	Other: 4 I Nursing H	lome	5 Residence	6 ☐Other (Specify)
iry	28b. Time of	28c.	Injury at	28d.	Describe how inju	ury occurred

Natural	5 Pending
2 Accident	investigation
3 ☐ Suicide	6 ☐ Could not be
4 ☐ Homicide	determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c.	Injury at Work?		28d. Desci
		M		1 Tes	2 🗆 No	İ

(MONIN, Day Year)	Injury M	1 Yes 2 No	0	
e. Place of injury - At he building, etc. (Specif		ory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number

. Certifier	1 Certifying Physician: To the best of my knowledge, death occur
(Check only	2 Medical Examiner: On the basis of examination and/or investiga
one)	and manner stated

ccurred at the time, date and place,	and due to the cause(s) and manner as stated.
stigation, in my opinion, death occur	rred at the time, date and place, and due to the cause(s)

5-8-2007

	17
29b. Signature an	d title of certifier

resignation, in my opinion, death occurred a	at the time, di	iate and place, and due	o trie cause(
29c. License number	29	9d Date signed /Month	Day Year)

). Name and address o	f person who completed	cause of death (Iten	n 23a) (Type, Print)

Mahesh P. Shah, M.D.

D-22634

State Registrar

298

Medical

Registrar DHMH 17 Rev 1/2001

2

State

119 C North Main St. Galena, MD. 21635

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2007

Registrar's Signature

Paul Donaher,

			1 - For State Regis	strar		_	State	of Mar	ylan	•	artmen rtificate			and M	lental Hy	giene Reg. No.	007	1603	8
	Dhuaiai		1. Decede	nt's Name	e (First, Midd	le, Last)									Date of Dea Month	ath Day	Year	3. Time of Death	
	Physici /Medio		LU	CIA	DOES										APRIL	26	2007	8:20PM	M
)	Examin	ner			f not institutio								Location of				ounty of Dea		
					A HILL	-		_					EVILL If Under					ANNE'S	
% -	Funeral		5. Social S			6. Sex	:]M 2]X)F		(In yrs.	last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt (Month, Da 2-03-1	n v, Ye <i>ar)</i> I Q 1 7	9. 81	rthplace (State or Forei country) CRMANY	gn
	Director		365-5 Usual Res		Decedent Decedent			90			ll				2-03-1	. 717	OI.	Minni	_
	yland		10a. State		10b. County	/		1	10c. Cit	ty, Town or Lo	cation						-	10d. Inside City Limit	
	Mar.	ţċ	MD		QUEEN	I AN	NE		C	ENTREV	ILLE							1 ZYes 2 □ N	Ю
	or 28	lre	10e. Stree	t and Nur	mber						10f. Zip	Code				10g. Citize	en of What C	ountry?	
	th wi	al C	220	FRE	DERICE	DR	IVE					2161	7			U	SA		
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at ODGE.	by Funeral Director		ever Marri	ed 2 Mai	ried	12. Was De Armed I 1 ☐ Yes If Yes, 0 Year or	Forces? 2 X No Sive			Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	1	I. Race - Am Black, Wh Specify: WI		
9	72 ho	ted		(5000	15. Deceder	nt's Educ	cation	4)		16a. Dece	dent's Usua	I Occupa	ition	t of work	ina	16b. Kind	of Busines	s/Industry	
21	thin 7	ple	Elemen		ndary (0-12)	isi grade		(1-4or 5+))		kind of woil DO NOT us)	i or work	,,,9	HOME	MAKER		
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,	Physician /Medical Examiner		shoo Immediat disease o resulting	ck, or hea le Cause or condition in death)	rt failure. Lis (Final n	r complited only on	Due to	each line www.	wn 5 conseq	Dui'SM	er the mod	e of dying	g, such as	cardiac	or respiratory ai	rest,		Approximate Interval Between Onset and Death	
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dical Examiner	Sequential any, lead cause. E Cause (D that initiat resulting i	led events	3			o (orasa:		, 									
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	quires that the de in signed by the a uld be detached t	þ	Part II. Oti	Dey.	ricant condit	ions con	ntributing to	death but	not res	sulting in the u	nderlying c	ause give	en in Part I				e contribute	to the cause of death? Probably 4 Unknow	٧n
I Records,	The ete h page	Completed		Q51	teoptr)३१उ									24a. Was autop perfo 1 \(\text{Yes}		24b. Were a prior to death?		ole f
/ita	Physician: Th r this certificete ral director, pag	Be (25. Was o		red to medica							1 -		of Deat	n (Check only c	ne)			
× ×	hysic this co	ပ္	1 🗆 Y	es 2		H	_			ER/Outpatie		-	NI	-	me 5 🗆 Resid			ecify)	
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	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medical (29a, Cert (Che one	ck only	Certifyi 2 Medica	ng Phys I Examir	ner: On the	he best of basis of e anner state	xamina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	nd place, ith occur	and due to the red at the time,	cause(s) a date and p	ind manner a place, and di	as stated. ue to the cause(s)	
	To the Comp	M	29b. Sign	ature and	title of certifi	1	Pron	Tus			290	. License	number DZS	93	3	29d. Date	signed (Mor	oth, Day, Year)	
	40)		30. Name	and addr	ress of person	who co	ompleted ca	use of dea	ath (Iter	n 23a) (Type,	Print)	Lone	e, E	183	ton, M	DZ	1601		
6	Sta Registi		31. Date 1	liled (Mon	th, Day, Year	7 20	0.77	Registrar	's Signa	ature	ions.				fon, M		· · · · · · · · · · · · · · · · · · ·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] []] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 25, Earle Stewart Dashiell Apr. 2:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 1 X M 2 □ F Months Hours Min. 218-09-4341 87 Director May 4, Usual Residence of Decedent 10a. State ?7 is marked other than "natural", or itame 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 4 Leeward Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Ford Griffin Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agency President permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9DGS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earle Stewart Dashiell Edna Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Dashiell/Wife 4 Leeward Court, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Educate Service Licenses 22 Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sicion and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical ilgned by the attending physical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by umoni9 2X No 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 🗌 Yes 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral dir Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death After t 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗌 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the th 29b. Signature and the of certified 29c. License number D20108

Registrar DHMH 17 Rev 1/2001

State

Box 68760,

Division of Vital Records, P.O.

Fox Lane, #222, Bowie, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 0 1 2007

31. Date filed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Certification: neral Director: , Medical

State Registrar DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

Millente

Margarita Korell MD.

31. Date filed (Month Ray

and manner stated

Assistant Medical Examiner

strar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 12, 2007

VOID

CERTIFICATE

2007-16041

SEE

CERTIFICATE #

2007-16042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Cherise Edwards-Payton 15 2007 0854 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner 1282 Patriot Lane P.G. Bowie 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 39 Yrs. Months Davs 1 □ M 2 1 X F Director 207-52-6174 1/11/1968 Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
3m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director MD P.G. Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 1282 Patriot Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black. White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivan Dennis Jr. Annie V. Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Otis E. Payton Jr./Husband 1282 Patriot Lane, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Department of Important: If its any Injury or o oonce, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/21/2007 |Greenville,NC 4 Donation 5 Dother (Specify) Homestead Cemetery 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licenses 3401 Bladensburg Rd. Brentwood, MD 20722 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Heart Failure 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 1 Tyes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐KNo 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 TXNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 🗚 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061810 May 3, 2007

State Registrar

MAY 03 2007 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Stuart Russell 600 N. Wolfe Street Baltimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of	of Marylar		artment rtificate			and M	lental Hyg	jiene leg. No.	007	160	43
, 48		88	1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea Month	th Day	Year	3. Time o	
	Physici /Medic		Eileen		Ε.		Earl	ey			4	29	2007	8:57	PΜ
	Examin		4a. Facility Name (If not institution	n, give street and nu	imber)		4b. City, T	own, or	Location of	f Death		4c. C	ounty of Death		
		e.	611 Schumaker 1	Lane				isbu				Wi	comico		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs.		If Under 1 Months	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth Cou	place (State intry)	or Foreign
Á	Director		217-28-4767	,	91	Yrs.					3-31-19	16_	Mary	land	
	and		Usual Residence of Decedent 10a. State 10b. County	,	10c. Ci	ity, Town or Lo	cation							10d. Inside C	ity Limits
	f sho	ō) III											1 ☐ Yes	2 X No
	289-	Director	MD Wicon 10e. Street and Number	nico	Sa	alisbur	10f. Zip (Code				10a. Citize	en of What Cou	ntry?	
	3a or		611 Schumaker	T.ane				804				USA		,	
	ns 2;	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.1	Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No-	T	4. Race - Amer	can Indian,	
(O	rita	Fur	1 Never Married 2 Mar		2 🛛 No		f Yes, specif			, Puerto	Rican, etc.)		Black, White		
ĕ	ours a	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, G Year or D	ive Dates:		1 Yes 2	K) No	Specify:			5	Specify: Wh	ite	
2-0	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Itams 23a or 28e-f show ent, the Medical Exaculter mest be multified at	Completed	15. Deceder	nt's Education est grade completed)		16a. Deced	dent's Usual kind of work	Occupa	tion uring most	of worki	na	16b. Kind	d of Business/Ir	ndustry	
2	ithin	npie	Elementary/Secondary (0-12)	College (life.	DO NOT use	e retired)				-	_		
2	ygier ygier yerth		Unk.				Barbei						metolog	у	
n n	be fill H	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	Maiden S	(umame)		
3	Mer Marke	To	William Bowen							-	Langma				
Maryland 21215-0036	12 sh and r Is m		19a. Informant's Name/Relations								l Route Numbe			p Code)	
a)	1 and 1ealth im 27		Helen Moran - C	cousin	20h I						isbury,			Charles	
Baltimore,	if its		1 X Burial 2 ☐ Cremation		State	Place of Dispo cemetery, crer							ation - City or T		
	tmen tant:		4 Donation 5 Other (S		Eve	rgreen		-		-4-2	007	Berl	in, Mar	yland	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or itams 23a or 28e-f show way injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service	Man D	110		. Name and			DOC	ınds Fun				
	do 2 o d		1/1/32 7	wy Ye	y ·						Salisb		Maryla		
.0			23a. Part1. Enter the disease, shock, or heart failure.	complications that only one cause on	each line.	th. Do not ent	er the mode)	ot dying	, such as	cardiac o	r respiratory arr	est,		Approxima Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a. /5/	Diration	2 P	neun	noni	R						
	/Medical Examiner		resulting in death)	Due 6	(or as a consec	quence of):									
		L.	Sequentially list conditions, if any, leading to immediate	b	(or as a consec	ruonco of):									
	sed nslt	Examiner	cause. Enter Underlying Cause (Disease or injury	₹ 500.0	(or as a consec	querice or,									
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Box	death certifica e attending ph id for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn							23	3d. Date of deliv	erv	
ň	d for	cia	in the past 12 months?	4□Pregi	birth 2∏Feta nant at time of c		Ectopic pre Other <i>(spe</i>						Month		Year
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J.	The law requires that the dei ite has been signed by the a bage 2 should be detached to	by P	Part II, Other significant conditi	ons contributing to d	leath but not res	sulting in the u	nderlying car	use give	n in Part I.		23e. Did to	bacco us	e contribute to	he cause of	death?
rds	quire in sig uld bi										1 🗆 Y	es 2	No 3∏Pro	bably 4 🗌	Unknown
00	w require s been sig	jete									24a. Was a	ın	24b. Were aut	opsy findings	available
Vital Records,	Physician: The lav this certificate has al director, page 2	Completed									autops perfor	med?	prior to co	mpletion of o	ause of
g		a)	25. Was case referred to medica	1					OF Disco	of Dooth	1 ☐ Yes	No No	1 🗆 Yes	2/L No	
>	s cert	To B	examiner2 1 ☐ Yes 2X No	Hospital:	Inpatient 2	ER/Outpatien	1 3 DOA	Othe	r. 4 🗆 Nu				Other (Speci	6()	
ō	g Phy er the		27. Manger of Death	28a. Date	of Injury oth, Day Year)	28b. Time of		c. Injury	at		28d. Describe h			·y/	
0	nding Path. r: After e funera	atio	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	ng (Mo) igation	nn, Day rear)	Injury	М	Work′ 1 □ Y	? ′es 2 🔲 l	No					
Division of	l or Attendi after death. Director: A in by the fu	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Place	e of Injury - At h	ome, farm, str	eet, factory,	office			28f. Location (S		Number or Rur	al Route Nun	nber,
	s after al Dire	Certification:	4 [] Florinciae	bullo	ling, etc. (Speci	ry)					City or Tow	n, State)			
	To the Hospitel or Attending Physician: To the Funatel Birdcot: Attenthis certific completely filled in by the funeral director,		29a. Certifier Certifyii	ng Physician: To the	e best of my kno	owledge, death	occurred at	t the time	e, date an	d place,	and due to the c	ause(s) a	nd manner as :	stated.	
	n 24 he Fi	edical	one)	Examiner: On the b	ner stated.	ation and/or in	vestigation, i	n my op	inion, deal	th occurr	ed at the time, d	ate and p	lace, and due t	o the cause(ŝ)
	To the within 2 To the complet	Σ	29b. Signature and title of certific		7	^	29c.	License	number		2	9d. Date	signed (Month,	Day, Year)	
			CAN S	M	M		1	120	62	18		5-	-1-0	7	
			30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,	Print)	- 1)	44 ^ -		
			Drend E. Con	call, ND (aste/	tpspi	e Pl	0	× 17.	73	Salist	1	W Z	1802	
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Dire permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State Registrar		C	ertificate o	f Deati	h		Reg. No	ZUU	/ ibl	144	
	2	1. Decedent's Name (First, Middle, La	st)					2. Date of I			3. Time of	Death	
Physicia		CARMEN LAMAR	FOGLE SR.					Month MAY	Da 7	y Year		\mathbf{P}^{M}	
/Medic	Aug.	4a. Facility Name (If not institution, giv			4b. City, Towr	or Location	n of Death		4c	. County of De			
Examin	er	FREDERICK MEMO		ጥአτ		ERICK				בסבט.	ERICK		
No. of the second	esh.	5. Social Security Number 6. S		ไก yrs. last birthda			er 24 Hrs.	8. Date of E	j Birth		irthplace (State o	r Foreian	
Funeral		2	IXM 2□F	80 Yrs.	Months Day	s Hours	Min.	(Month, I	Day, Year)) _ (Country)	, or orgin	
Director		Usual Residence of Decedent		00				oct.	, 19	20 110	ryland		
and		10a. State 10b. County	1	0c. City, Town or	Location						10d. Inside Cit	ty Limits	
lary sho	ō	M . 1 . 1			.,						1 □Yes	2 X No	
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vith vith					101. Zip Cou		_		log. Cit				
ath v	Funeral	11734 Cash Sn	T			2175				U.S.A			
tems	nu	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	Was Decedent of If Yes, specify C	f Hisp <i>a</i> nic (uban, Mexic	Ongin? (Spe can, Puerto	ecify Yes or I Rican, etc.)	No-	Black, Wh	nerican Indian, nite, etc.		
orl	by F	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 □ Yes 2 🗖 N	o <i>Specii</i>	fy:			Specify:			
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		3 Widowed 4 Divorced	Year or Dates:								White		
72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Gi	cedent's Usual Oc ve <i>ki</i> nd of work do	e during m	ost of work	ing	16b. K	(ind of Busines	ss/industry		
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as H as H as A oth	Be	17. Father's Name (First, Middle, Last,				18. Mot		e (First, Midd					
Men Men	၉	Allan W. Fogle	2				Am	y Viol	et C	labaugh	1		
s mg		19a. informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Stre	et and Num	nber or Run	al Route Nun	ber, City	or Town, State	, Zip Code)		
and alth		Anna M. Fogle/ wi	ife	117	34 Cash 9	mith	Rd.	Keyma	ir, MI	D 21757	•		
oth oth		20a. Method of Disposition	-	20b. Place of Dis	position (Name of rematory or other)	lace)	[Date	20c. Lo	ocation - City o	or Town, State		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 XX urial 2 □Cremation 3 □ 4 □Donation 5 □Other (Specif			e Cemeter	· i	5/10	/2007	Wood	dsboro,	MD		
artm artm orta		21. Signature of Fymeral Service Lice			22. Name and Ad								
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12. 20.		23a. Part1. Enter the disease, or com	inlications that caused th							10 2175			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final											
Physician	-	disease or condition resulting in death)	_a	~~ 9	C 2 1 C	~					3 da	11	
/Medical Examiner		1000mmg m 000mm/	Due to (or as a	consequence of):							,		
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certificate be executed rding physician and ise as the burial-transit	/Medical		_d										
rtifica ng ph as t	Jed	IE ECMAN E.											
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deal e att	ic:	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at til		5 ☐ Other (specify				.	Month	Day Y	/ear	
t the	Physicia	9 ☐ Unknown	9□Unknown										
s tha		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause	given in Par	rt I.	23e. Dio	d tobacco	use contribute	to the cause of d	eath?	
luire	d by	Stroke						1 [Yes 2	□ No 3□	Probably 4.0t	Jnknown	
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ne lay has ye 2	d m							aut	topsy rformed?	prior to	autopsy findings a o completion of ca	ause of	
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hysl this o	၉	1 Yes 2 No	1	2 ER/Outpat	IGHT 2 DOY					6 □Other (Sp	pecify)		
ng P	ü	27. Manner of Death 1. ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time		jury at ork?		28d. Describ	e how inju	ry occurred			
endi	ati	2 ☐ Accident investigation			M 1	☐ Yes 2[□No						
r Att	ij∣	3 ☐ Suicide 6 ☐ Could not be determined		- At home, farm, (Specify)	street, factory, offi	e			(Street ar		Rural Route Num	ber,	
ital c rs aft al Di	Certification:												
hou uner			nysician: To the best of miner: On the basis of e									.)	
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u	edical	one)	and manner state		veoligation, il II	, opinion, 0		ica at the till	o, uale di	o piace, and di	ue to the cause(S	,	
To t To t	ž	29b. Signature and title of certifier			29c. Lice	nse numbe	r		29d. Da	ite signed (Mor	nth, Day, Year)		
		Muhall	evan "	0.0	D	1161	9		Ma	- 4 11	2007		
		30. Name and address of person who			e, Print)								
9		Michael L			mas John:	on Dr	., Su	ite E	, Fre	derick,	, MD 2170	J2	
Sta	te	31. Date filed (Month, Day, Year)		s Signature									
Registra		MAY 1 7 200	1 Jale 15.00	A. M									

Registrar DHMH 17 Rev 1/2001

		Please Type or Print in	Black	Indelible Ink.	Ensure A	II Copies	Are Leg	jible.	
		State of Maryla		•		Mental Hy	giene		
		1 = State Registrar		Certificate of I	Death	2. Date of De	Reg. No.	107	16045
Physicia	an	1. Decedent's Name (First, Middle, Last)				Month April	Day	Year	3. Time of Death
/Medic Examin		Virginia Townsend Fowler 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	11111111		2007_ ty of Death	11:50 P [™]
LAGIIIII	۲'	Anne Arundel Medical Center		Annapol				Aruno	del
Funeral		5. Social Security Number 6. Sex 7. Age (In yr	rs. <i>last birtho</i> Yn	Months Davs	If Under 24 Hrs. Hours Min.	(Month, Da		9. Birth	place (State or Foreign intry)
Director		247-16-2011 89 Usual Residence of Decedent		s.		Sept.8	, 1917	_ Geoī	rgia
ryland how		10a. State 10b. County 10c. (City, Town o	r Location					10d. Inside City Limits
ne Ma 8a-f s	Director		nnapol				40- 011	(14/1-14/0	1 Yes 2 No
after death with the Maryland or items 23e or 28a-f show miner must be notified at		10e. Street and Number		10f. Zip Code			10g. Citizen of		,
death	Funeral	3307 River Crescent Drive 11. Marital Status 12. Was Decedent Ever in	U.S.	21401 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	United	ace - Amen	can Indian,
after or ite	/ Fui	1 Never Married 2 Married 1 Yes, Give		1 ☐ Yes XX No	Specify:	to Hican, etc.)	Spec	ack, White,	hite
hours tural";	d by	Widowed 4 □ Divorced Year or Dates:	16a D	ecedent's Usual Occup	ation		16b. Kind of	* ***	
in 72 n "nat	Completed	(Specify only highest grade completed)	(0	Give kind of work done of the control of the contro	during most of wor	rking		ederal	•
d with giene er tha	Com	Elementary/Secondary (0-12) College (1-4or 5+)		Accountant				ernmen	
be file tal Hy d oth event	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nar			ıme)	
d Men narke	2	Philip Clayton Townsend 19a. Informant's Name/Relationship (Type. Print)	10b N	Mailing Address (Street	Willie A			e Ctoto 7	in Code)
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", any injury or other treumatic event, the Medical Exagone.		Virginia R. Ramsev / Daughter		Norwood R		napolis.			
of Hear item		20a. Method of Disposition 20b	D. Place of D	isposition (Name of crematory or other place		Date	20c. Location		
Page ment c		T Burial & Cremation 3 Hemoval from State		re Cremato	1	/2007	Baltimo	ore, N	Maryland
permit. Departimporti		21. Signature of Fundral Service Licensee		22. Name and Addre					al Home,Inc
□ □ = 42 OI		23a. Part1. Enter the disease, or complications that caused the de	eath Dono	147 Duke				apolis	Approximate
Dhuaisian		shock, or heart failure. List only one cause on each line.	100		a de la cardia	o or respiratory t	arrest,		Interval Between Onset and Death
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The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medica	IF FEMALE:							
eath certific attending pl	ian/	23b. Was decedent pregnant 1 Live birth 2 F	etal death	3 ☐ Ectopic pregnancy	/			Date of deliv	very Day Year
he de the a	ysic	1 Yes 2 No 9 Unknown	of death	5 ☐ Other (specify) _					
that the de ned by the	y Ph	Part II. Other significant conditions contributing to death but not r	resulting in th	ne underlyi n g cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to f	the cause of death?
w requires been sign	ed by	Breast Cancer				1 🗆	Yes 2 No	3 □.Pro	bably 4 □Unknown
ne law requ has been ge 2 shoul	Completed	HYPERTENSION				24a. Was	ppsy		opsy findings available ompletion of cause of
	Con					perf 1□ Yes	ormed?	death? 1 ☐ Yes	2 □ No
Attending Physician: The I. releath. r death. ector: After this certificate ha by the funeral director, page?	Be	25. Was case referred to medical examiner? Hospital:	TED/O.A	etient 2 DOA Oth	26. Place of Dea				
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ath. nr: Afte	atio	1 Matural 5 ☐ Pending (Month, Day Year, 2 ☐ Accident investigation	r) Inju		k? Yes 2 □ No				
or Atte ter de irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - Al building, etc. (Spe	t home, farm ec <i>ify)</i>	n, street, factory, office		28f. Location City or To	(Street and Nun own, State)	nber or Rur	ral Route Number,
pital ours af	Ce	29a. Certifier 1 Certifying Physician: To the best of my	knowledge (death occurred at the fi	me date and place	e and due to the	e cause(s) and r	manner as	stated
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the funeral preserve.	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.							
To th Withir To th comp	Me	29b. Signature and title of certifier		29c. Licens			29d. Date sign	ned (Month)	, Day, Year)
W		Mousay Hospitalist		P6	4481		04/3	0 0	17
0		30. Name and address of person who completed cause of death (i	tem 23a) (T	ype, Print) AC PKI	A FIL	MNAPO	110	Mh -	-7111-01:
Sta	te	31. Date filed (Month, Day, Year) 32. In gistrar's Sig			1, 1	. 44/1/0	MJ; 1		2140
Registr	ar	MAY 0 1 2007 Keen	J.	Greek					
MH 17 Rev 1/20	001			•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 11:45P^M Karen H. Fields April 2007 29, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 15220 Ganley Road Montgomery Boyds If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F Months Days Hours Min. 218-38-4315 66 March 21,1941 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Boyds Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15220 Ganley Road 20841 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 21 No Specify: lf Yes, ਯਾਦ Year or Dates: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ U.S. Food and Drug, Adm Research Biologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederic Hamburger Maravene Deveney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon B. Fields - Husband 15220 Ganley Road, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 5/1/2007 Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Ovarian Carcinoma years Due to (or as a consequence of): Adenocarcinoma of Ovary unknown Due to for as a consequence off: Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

death certificate be executed

P.O. Box 68760

Records,

Division or Vital

or Attending

Hospital

Department of h Important: If ite any Injury or of

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show e notified at

ed other than "natural", or items 23a or event, the Medical Examiner must be r

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or item

Hygiene.

altimore, Maryland 21215-0036

death v

Director

Funeral

Completed by

Be ပ

Examine Physician/Medical as use for Completed by rector. Be 2 Certification:

physician and the burial-transit ed by the a detached for cate has been signed by page 2 should be detact certificate 24 hours after death e Funeral Director: filled in by Medical within 24

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D21531 May 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Pushkas, M.D., 11510 Old Georgetown Road, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) egistrar's Signature

03 2007

Registrar

			For State Registrar		State	e or iviar	•	partment of e <i>rtificate of</i>				giene Reg. No	0007	16047
"	Physicia	20	1. Decedent's Nam	ne (First, Middle	e, Last)						2. Date of Dea Month	Da		3. Time of Death
	/Medic			ristine]							Apri		, 2007	т.ю рм
	Examin	er	4a. Facility Name (d number)		4b. City, Town,				40	C. County of Death Montgomery	
			5. Social Security	5 Columb	ia Pike 6. Sex	7 Age	(In yrs. last birthda		Sprin		8. Date of Birt	th		
	Funeral Director		235-50-3		1 M 2 K	F	74 Yrs	Months Days		Min.	(Month, Da	y, Year		place (State or Foreign ntry) ecce
91	a mon safetanan		Usual Residence								ildy ZIS	LJJZ		
	nylane how at		10a. State	10b. County		1	10c. City, Town or	Location						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma 3a-f s tiffied	cto	Maryland	Mont	gomery			Silver Sprin	ıg 					
	be filed within 72 hours after death with the Maryland Hydjene. d other than "natural", or items 23a or 28a-f show to other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	10e. Street and Nu					10f. Zip Code				10g. C	itizen of What Coul	
	s 23a			Columbi		Decedent Cu	vor in II C 1)901	Origin? (Cno	oifu Vac or No		U.S.A. 14. Race - Americ	
	er de item ner n	Funeral	11. Marital Status	ried 2🗶 Mari	Arme	Decedent Eved Forces? /es 2 X No		Was Decedent of If Yes, specify Cu	ban, Mexic	can, Puerto	Rican, etc.)	-	Black, White,	
35	Irs aff	by F	_	4 Divorced	If Yes	s, Give or Dates:		1 ☐ Yes 2 🔼 No	Special Special	fy:			Specify:	White
5-0036	2 hou	ted	/Cos	15. Deceden	it's Education st grade comple	tad)	16a. De	cedent's Usual Occ	upation	act of worki	na	16b. 1	Kind of Business/In	dustry
22	within 7 iene. than "n the Medi	Completed	Elementary/Sec		1	ge (1-4or 5+)) lift	ive kind of work don e. DO NOT use retir	ed)	OSI OI WOIKII	ng .		_	
7	filed wil Hygien Ither the	Co	12					Manager	1				Restauran	it
⊆	ild be filk fental Hi ked oth ic even	Be	17. Father's Name	e (First, Middle,	Last)				18. Mo		(First, Middle,			
<u>\sq</u>	2 should be and Menta Is marked raumatic ev	은			Caravaso		40). 14	W Add (Ot	-4/ 8/		nia Kost			- 0-4-1
10	12 sh h and 7 Is n traun		19a. Informant's N					ailing Address <i>(Stree</i> 4 5 Columbia				-	•	
	ges 1 and 2 should tof Health and Mer If Item 27 is marke or other traumatic		20a. Method of Dis		- Husband			sposition (Name of crematory or other p.			Date Date		ocation - City or T	
ັດ	: Pages tment of I tant: If Ite		1 ₺ Burial 2	☐Cremation	3 □Removal f	from State			1	5/4/	2007	Q# 1:	ver Spring,	Maryland
	permit. Pag Department Important: I any injury o		21. Signature of F	5 Other (Suneral Service		٠	Gate of h	eaven Cemete 22. Name and Add	ress of Fac	cility			ver bpring,	intyruna
n	Dep Imp any onc		1 Am	ando	Rud	luco		Hines-Rina	lamosh:	ire Ave	nue Sil	ver	Spring, Mar	yland 20904
g ^a .			23a. Part1. Enter	the disease, o	r complications t	that caused	ne death. Do not	enter the mode of d	ying, such	as cardiac c	or respiratory a	rrest,		Approximate Interval Between
	Physician	i li	Immediate Cause	(Final				ary Fibrosis						Onset and Death
	/Medical		resulting in death				consequence of):	aty Fibrosi.	.					
	Examiner		Sequentially list of	onditions				e Lung Dise	ase					
	p ti	iner	cause (Disease of	immediate lerlying -	2 01	e as to) tot es a	considerate of).							
	ecute and I-trans	Examin	that initiated even resulting in death)	its	c	e to (or as a	consequence of):							
Ğ,	ficate be executed physician and is the burial-transit	al E												
98760	ficate physis the	edical			d									
NOX ROX		M/M	IF FEMALE: 23b. Was decede	ent pregnant		s, outcome p		• Ca					23d. Date of deliv	rery
	death atte	Icia	in the past 1	2 months?	4□1	Pregnant at ti	! □ Fetal de <i>a</i> th ime of death	3 □Ectopic pregnar 5 □ Other (specify)					Month	Day Year
л Э	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use	Physician/M	9 ☐ Unknow	/n		Jnknown								
	ss tha	by P	Part II. Other sign	nificant conditi	ions contributing	to death but	not resulting in th	e underlying cause (given în Pa	rt I.				the cause of death?
ğ	equire en si ould h										1 📗	Yes	2 No 3 Pro	bably 4 Nunknown
Vital Hecords,	law r as be	Completed									24a. Was auto	psy	prior to co	opsy findings avail <i>a</i> ble ompletion of cause of
<u> </u>		Con									1□ Yes	ormed? 2 🔼 N	death? Io 1 ☐ Yes	2□ No
/Ita	clan: ertific	Be	25. Was case refe examiner?	erred to medica	al Hospital:			lo		ace of Death	h (Check only o	one)		
5	chysical this call dire	ို	1 Yes 25	-		1 Inpatien Date of Injury	t 2 ER/Outpa	tient 3 DOA			me 5 A Resi 28d. Describe		6 □Other (Speci	ify)
Ę.	fing I	ioi:	27. Manner of De	5 Pendi		(Month, Day		ry V	ork? ☐ Yes 2	İ	zou. Describe	now mj	ury occurred	
Division or	death death ctor: y the	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be 28e.	Place of injur	y - At home, farm	street, factory, office					_ and Number or Rui	ral Route Number,
2	after after Dire	Certification:	4 ☐ Homicide	deterr	Illieu	building, etc.	(Specify)				City or To	wn, Sta	ite)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it		29a. Certifier					eath occurred at the						
	n 24 he Fu	Medical	(Check only one)	2 Medica		manner stat		r investigation, in m	y opinion,	death occur	red at the time	, date a	ind place, and due	to the cause(s)
	To t To tl	Ž	29b. Signature ar	nd title of certific	er				nse numbe			29d. D	ate signed (Month	
	6			4. / Far				D	479	28			4/30/00	<u> </u>
)		30. Name and ad						oot===	MD 07	2002			
	la la la la la la la la la la la la la l		Lily 31. Date filed (Mo					e, #304, Wh	eacon,	rau ZU	0902			
	Sta Regist		J. Date fied (M	O YAN	3 2007	Palin	r's Signature	parte)						

			For State of Maryla 1 - State Registrar		partment of Health and N ertificate of Death		ene g. No 0 0 7	16048
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		David Holland	Frischk	orn	Month May	Day Year 2007	3:45 A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Dea	
			12531 Ocean Reef		Berlin		Wicomi	
	Funeral		1⊠M 2□E	rs. last birthday 7 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	thplace (State or Foreign ountry)
	Director		182-22-1204 7	/		July 31	, 1929 Pe	ennsylvania
	yland			City, Town or L	ocation			10d. Inside City Limits
	a-fal	tor	Maryland Carroll	Mt. A	Airy			1. ☑Yes 2 ☐ No
	or 28	Directo	10e. Street and Number		10f. Zip Code	10	g. Citizen of What C	ountry?
	ath w		809 Roller Coaster Court		21771		United S	
5-0036	permit. Pages 1 end 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: Kol		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
1215-0	vithin 72 ho ne. han "natur e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	sing 1	6b. Kind of Business	
7	iled v Hygie ther t		1.7. Father's Name (First, Middle, Last)	St	team Engineer	e (First, Middle, M	Hospit	:a1
Maryland 2121	d be f ed of	o Be	Frederick Frischkorn		Edna H		aluen Sumame)	
<u></u>	Shoul nd Me mark	ပ	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street and Number or Rui		City or Town, State.	Zip Code)
Š	nd 2 alth a 27 is r trat		Gerald T. Frischkorn / Son	1				yland 21794
altimore,	of Heis		20a. Method of Disposition 20th	o. Place of Disp	position (Name of	Date 2	Oc. Location - City o	
Ē	Page nent c		1 2-bunal 2 Cremation 3 Premoval from State		nael's Cem. May	оо́7 м	t. Airy,	Marvland
ä	epartr epartr poort y inj		21. Signature of Funeral Service Licensee	2	22. Name and Address of Facility St			
m 	E = 202		teto		E. Ridgeville Blv			land 21771
			23a. Part 1. Enter the disease, of complications that caused the dishock, or heart lailure. List only one cause on each line.	. A	-		st,	Approximate Interval Between Onset and Death
ź	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aryA	treen Desease teart failure			Shoot and Dodgi
	Examiner		Due to (or as a cons	requence of):	La & Cailing			
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a dons		reavi fenture	<u></u>		
	d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Fibr	illation			
, O	en an en an rial-tr		resulting in death) Last Due to (or as a cons					
68760,	ficate be executed physicien and s the burial-transit	edical	d					
			IF FEMALE:					
P.O. Box	The law requires thet the death certif ste hes been signed by tha ettending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
	w requires thet the de been signed by tha e should be detached f	þ	Part II. Other significant conditions contributing to death but not a Diabetes Mellitus	resulting in the t	underlying cause given in Part I.	23e. Did toba		o the cause of death?
Division of Vital Records,	hysiclan: The law requinis certificate hes been I director, page 2 should	Completed				24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
II a	clan: ertific actor,	Be (25. Was case referred to medical examiner?			h (Check only one		0 1
5	Physi this o	2		ER/Outpatie			ce 6 ⊠Other (Spe	city) Residence
5	ding h. After funer	50	27. Manner of Death ↑ Natural 5 ☐ Pending ↑ Accident investigation (Month, Day Year,	28b. Time of Injury	ol 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	/ injury occurred	
<u>s</u>	deat deat ctor: y the	flca	3 Suicide 6 Could not be 28e. Place of Injury - A	t home, larm, st		28L Location /Stre	et and Number or R	ural Route Number
2	after t Dire	Certification;	4 Homicide determined building, etc. (Spe	icify)	actaly, since	City or Town,	State)	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, p.	edlcal (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of exam and manner stated.	nowledge, deat	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the Comp	ž	29b. Signature and little of certifier		29c. License number		d. Date signed (Mon	
1	140		1 thing		US8755	1	Mary 2,	2004
	1000		30. Name a d address of person who completed cause of death (1) 9714 lfealthway Drive	Berli	n, MD21811		0	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registar's Signary 0 4 2007	inature	Sparle			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

lark Anthony	y Gnit	1-		e of Death	o Mental Hy	giene Reg.	No. 200	7 1604
Phys Medical Exa		1	Decedent's Name (First, Middle,Last) Mark Anthony Grifo, Jr.			2. Date of Death Month D April 27, 200	ay Year	3. Time of Death 1400 hrs
N.	,		a. Facility Name (if not institution, give street and number)		Location of Death	745111 27, 200	4c. County of Death)
Funer	ral l	5	503 Fox Den Lane Social Security Number 6. Sex 7. Age (In yrs. last birthda	Millersville y) If Under 1 Yea	ar If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Bir	
Direct		Ļ	212-21-1365 1XM 2 F 19	Yrs. Months Day	/s Hours Min.	10/18/1	987 Foreig	nutry) MD
Maryland 28a-f show any		1	Oa. State 10b. County 10c. City, Town or L MD Anne Arundel 10c. City, Town or L	Mille	ersville			10d. Inside City Limits 1 Yes 2 X No
the Mary			0e. Street and Number 503 Fox Den Lane	10f. Zip Code 21	1108	10g	. Citizen of What Cou USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 23 snarked other than "natural", or items 23a or 28a-f she	er must be		X Never Married Armed Forces? 1 Yes 2 X No	3. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 X No	n, Mexican, Puerto I		White, etc.	ican Indian, Black, nite
hours a	ledical Examin		15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Education (Specify only highest grade completed)	cedent's Usual Occupa			6b. Kind of Business/	Industry
036 ithin 72 ne.	the Medical Exam		Elementary/Secondary (0-12) College (1-4 or 5+) 1	College St	tudent		Coll	.ege
21215-0036 ould be filed within 7 Mental Hygiene.	ent, the h		7. Father's Name (First, Middle, Last)		18.Mother's Name Jennife		iden Surname)	
212 hould be nd Ment is mark	tic even	2 1		Mailing Address (Stre	et and Number or R	ural Route Numb		
- P = F	Ē			503 Fox Der			LIE, MD 2	
Baltimore, Neuron Permit. Pages I and Department of Healt Important: If item		L	Burial 2 X Cremation 3 Removal from State crematory	or other place) Crematory	Apı	2007	Baltimore	-
Physici		1	3a. Parl i. Enter the disease, or complications that caused the death. Do not e	495 Gov. F	Ritchie Hw	vy, Seve	rna Park,	Approximate Interval
/Medic	cal		failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):					Between Onset and Death
			Sequentially list conditions, f any, leading to immediate b					7
P .	nsit	Yall	cause. Enter Underlying Cause Dispass or injury that hillated events resulting in death) Last C. Due to (or as a consequence of):					-
execute	he burial - trar	3	d. UNPENDED AMENDED					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been stoned by the attending physician and	for use as the burial - transit	Tilysiciali/imed	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ukknown 2 Ukknown 2 Ukknown 3 Ukkno	Fetal death 3 Other (Specify)	Ectopic pregna	ncy	23d. Date of deliver Month	y Day Year
O. Bo at the dea	sched		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	given in Part I.		acco use contribute to	
IS, P.C quires that	ald be d	red by				1 Yes	2 ✓ No 3 Pro	utopsy findings available
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the safter dead of the this certificate has been stoned by	filled in by the funeral director, page 2 should	nataldillon				autopsy perform 1 ✓ Yes 2	ned? death?	completion of cause of res 2 No
tal Reciant The	rector, p	2 3	25. Was case referred to medical examiner? Hospital: 1 tanalignt 2 EP/Outs		Other		esidence 6 🗸 Othe	
of Vi	neral dir		1 ✓ Yes 2 No	atient 3 DOA ne of Injury 28c. Inj	jury at Work?	28d. Describe ho	w injury occurred	er. Scene
sion trendin death.	y the fu		2 Accident Investigation Apr 27, 2007 1355 h	rs	Yes 2 V No	Subject hang		
Divis	illed in b	Certification.	3 V Suicide 6 Could not be determined (Specify) At home		or Town, Sta		ural Route Number, City	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	2 > 1 2	ਰ	29a. Certifier Check only Certifying Physician: To the best of my knowledge, death one) Medical Examiner: On the basis of examination and/or invegated manner stated.	occurred at the time, estigation, in my opinio	date and place, and on, death occurred a	due to the cause t the time, date a	(s) and manner as stand place, and due to t	ted. he cause(s)
	5	INIE	29b. Signature and title of certifier		nse number C.M.E.		29d. Date signed (Me April 28, 2007	onth, Day, Year)
Kal		-	30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner	111 Penn Stree	et, Baltimore, M	D 21201		
	Sta	te	B1. Date filed (Month, Day Year) 1 2007 32. Red strar's Signature	South				
Re	gistr	-11	MATERIA O	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 1, 2007 Year **Physician** Ida GRAFF 9:27 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Laurel Regional Hospital Laure1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Day, Year | Aug. 18, 1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Yrs. 083-28-7992 87 Poland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Madical Exposiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1009 West Nolcrest Drive 20903 United States 23a death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. e filed within 72 hours after all Hygiene.

Other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: white à 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked oth Be Menachem Mendel Friher Sara Devorah Poznansky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Haas Ct., Davidsonville, MD Gil Graff, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 0 = 0 1 ABurial 2 Cremation 3 Removal from State artment ortant: I injury o 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 05/03/07 Adelphi, MD pernit.
Departri 21. Signature of Funeral Service Licen Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 5 Days Dehydration resulting in death) /Medical Due to (or as a consequence of): Examiner 2 Weeks Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Anorexia ua to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Rheumatoid Arthritis Years Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Decubitis Ulcers Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 autopsy performed? certificete 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2√2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

P.O. Box 68760. of Vital Records. To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After th
completely filled in by the funeral Certification: Division

Baltimore, Maryland 21215-0036

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J.

5 Pending

title of certifier

investigation

6 Could not be

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

4 - Homicide

M.D., 2415 Musgrove Road, Suite 209, Silver Spring, MD 20904 Ginsberg,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

М

1 ☐ Yes 2 ☐ No

DO025344

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Madeline Aurelia Gateau May 7, 2007 5:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 44318 Finnacom Road Tall Timbers St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 💢 F Director 577-18-2835 93 03/08/1914 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 No Director Tall Timbers Maryland | St. Mary's 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural', or items 23a or dical Examiner must be r 44318 Finnacom Road 20690 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 ₩ Widowed 4 □ Divorced White Completed Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home other 1 Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Branson Daffan Susie Staples 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Mori/ Son-in-Law 44318 Finnacom Road, Tall Timbers, Maryland 20690 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Cath. Cem. 05/11/2007 | Valley Lee, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature Tuneral Servine Licensee M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 Jr. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No Completed 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 106 24a. Was an autopsy performe page certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Manner of 28c. Injury at Work? Certification: 1 Natural
2 Accident Injury 5 | Pending investigation 1 Yes 2 No Director: , in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a the Funeral C mpletely filled i Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 41860 Miss Bessie Drive, Leonardtown, Maryland 20650 James C. Boyd, 31. Date Med (Month, Day, Year) State 2007

Registrar

MAY 0 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Harry Edward Lyman Gist May 2, 2007 0956 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2 ☐ F Yrs. 79 Feb 17, 1928 Maryland Director 213-24-9527 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County at 28a-f sh notified 1 ☐ Yes 2 No Directo Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or ? 2150 Old Washington Rd. USA 21157 Funeral 'natural', or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than Elementary/Secondary (0-12) College (1-4or 5+) Concrete Finisher Gist Brothers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental I Josephine Rickell Charles Hammond Gist 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau Wife Shirley A. Gist 2150 Old Washington Rd. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removal from State Deer Park Cemetery 5/6/2007 Smallwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service License 412 Washington Rd. Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin a shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Tyes 2 No Probably 4 Unknown Completed 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 25 Be

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

physician s the burial attending pl cate has been signed by the page 2 should be detached funeral dir within 24 hours after death.

To the Funeral Director; Α completely filled in by the fu

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Medical Certification:

State

Registrar

29a. Certifier

The law requires that the death certificate be executed

or Attending Physician:

the Hospital

0

Division or Vital Records, P.O. Box 68760,

					1 Yes 2 No 1
Was case referred to medical				26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Othe
Manner eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c.	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre

3□ Suicide 6 Could not be determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Westminster

	/							
29b. Signature	nd title	of cer	tilier		29e-License number	2/	29d. Date signed	(Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

555 S Cent Ua

31. Date filed (A 2007 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month . **Physician** 1905 Thomas Gilliam /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carpital Hing 1207 Addison Road # 339 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) , Funeral Days Hours 1 3 M 2 □ F 81 Yrs Director 155-18-2855 Farmville, Va 2/28/26 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1∏Yes 2□No Director P.G. Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 1207 Addison Road # 339 by Funeral 20743 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th Washington Post Newspaper Inserter other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen Gilliam Mary Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sweetie Mae Gilliam/Wife 4842 West 43rd St., Chicago, Illinois 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: if Ite any injury or of once. 1X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/5/07 Evergreen Cem. Salem, New Jersey H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee auc 1 Well 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Bowel Obstruction **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 ∏Yes 2 ∏No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No certificate 1 Yes 25. Was case referred to medical examiner?

1. So a constant of the constant o Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H2055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Salvador Sylvester, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State MAY 03 2007

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Registrar

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	/Medic		Richard David Har	<u>-</u>				1 - 1 - 1 - 1	April	26	2007	3:55	Рм
	Examir	er	4a. Facility Name (If not institution, give Riva Terrace V	street and number)			4b. City, Town, or Arnold	Location of Death		4c. County	Arun	de1	
1	Funeral		5. Social Security Number 6. Se		(In yrs. last birti	hday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1			or Foreign
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36	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	oy F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 N If Yes, Give Year or Dates:	lo		I□Yes 2🕱 No	Specify:		Specif	/ :	White	
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anc	tal do	Be C	Park D. Harrington					Viola Ru			ne)	,	
Maryland		To	19a. Informant's Name/Relationship (T)		19b.	Mailin	g Address (Street a				State, Zip	Code)	
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Baltimore,	permit. Pages 1 and i Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State			sition (Name of natory or other plac	re)	Date	20c. Location	•		
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н	7-3		23a. Part1. Enter the disease, or comp	lications that caused	the death. Do n	1						Approxima Interval Be	
	Physician [*]	8 10	shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each lin	e. ONAR	V	PRTI	ery 1	SOAR	0		Onset and	Death
Z	/Medical		resulting in death)	Due to (or as a	a consequence of	of):		1	11/7)	C.		Jyc	7312
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Division	Attending r death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(World, Day	(rear)	njury		Yes 2 □ No					
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	Hospital of the hours at Funeral Distriction filled i		29a. Certifier Certifying Phy	sician: To the best of	of my knowledge	death	occurred at the tin	ne date and place	and due to the o	ause(s) and m	anner as s	tated	
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	To the within 2 To the comple	Me	29b. Signature and title of certifier	01:	11		29c. Licenso		2	29d. Date signe	d (Month,	Day, Year)	
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	Kny	-	30. Name and address of person who delined.					adv Side	Marvlar	r nd 2076	4		

State Registrar 31. Date filed (Month, Day, Year) 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death М Donald Eugene Hood Apr. 26, 2007 3:00a 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Baltimore Washington Medical Ctr. Glen Burnie 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sep. 24, 7. Age (In yrs. last birthday, 5. Social Security Number Days Min 1X M 2 □ F 83 PA 219-12-5990 Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a State 1 ☐ Yes 2X No MD Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 504 Enclave Trail 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🖾 No White Specify: Specify WWII 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Earl Hood Marie Auer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Margaret G. Hood/Wife P.O. Box 369, Severna Park, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Apr. 26, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 2007 22 Name and Address of Facility 21. Sonature of Fineral Service ic inse P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23 Pa . Enter the disease, or complicately ock, or heart failure. List only one Immediate Caus (Final disease or condition resulting in de th) Levos demi, 200 Cronw Due to (or as a consequence of):

Physician /Medical **Examiner**

Department o Important: If any injury or once,

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Completed by

Be

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physician and s the burial-trans as attending p for use as signed by the a d be detached f has page 2 certificate or Attending Physician: this

requires that the death certificate be executed

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or High) that initiated events resulting in death) Last	b			-		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic			23d. Date of delivery Month Day Year	
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
				24a. Was an autopsy performed 1 Yes 2 ▶		
25. Was case referred to medical			26. Place of De	eath (Check only one)	1 Leaves on the state of	
examiner? 1 ☐ Yes S☐ No	Hospital: 1 ☐ Inpatient	PER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 ⊡Other (Specify)	
27. Manner of _eath 19 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury M 1 □ Yes			28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, state)	
29a. Certifier (Check only one) Certifying Phylogene Medical Example 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and place on, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)	
29b. Signature and title of certifier		- 2	29c. License number	29d.	Date_signed (Month, Day, Year)	

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State AMEND#26perMD5/3/07, BMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1:01 P M Lawrence Alan Hill April 30, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda If Under 1 Year If Under 24 Hrs. Montgomery

9. Birthplace (State or Foreign Country) Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 → M 2 □ F Min. Director Nov. 15, 1963 Washington, DC 220-86-9679 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatle event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 Star Lane 20852 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔀
If Yes, Give
Year or Dates: 1 X Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: SpecifyWhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Handyman Janitorial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles Dennis Hill, Florence Elizabeth Mosely 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Star Lane, Rockville, Maryland 20852

of Disnosition (Name of Date 200. Location - City or Town, State Charles Dennis Hill, Sr./Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery May 4 □ Donation 5 □ Other (Specify) 2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final) u Imonam addio **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner manu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the interest of the cause). Due to (or as a consequence of): Examiner use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. maidiem. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 □ Yes 2 □ No 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by boo vascular 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2200 page 2 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2X ER/Outpatient 3 DOA 1 ☐ Inpatient Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d Pate signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

6520

Registrar's Signature

Mocroray Blud.

Lietnesva,

30. Name and address of lesson who completed cause of death (Item 23a) (Type, Brint)

KLOOY

03

31. Date filed (Month, Day, Year)

			For State Registrar	State of Marylar		artment of F		nd Mental I	Hygiene Reg. No.	007	16057
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Month	Death Day	/ Year	3. Time of Death
	Physici /Medi		Margaret May 1	Hildebrand				May		2007	1500 M
	Examir	ner	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of [Death	4c.	County of Death	1
	gr. A	300	Carroll Hospita 5. Social Security Number 6. Sex		In a birt in i	Wes If Under 1 Year	tmins		B: at	Carro	
100	Funeral Director			M 254F	Yrs	Months Days		Min. (Month	Birth Day, Year)		nplace (State or Foreign untry)
			Usual Residence of Decedent	88	<u> </u>			Dec	02 19	918	MD
	yland how		10a. State 10b. County	į.	ty, Town or Lo	ocation					10d. Inside City Limits
	e Ma	cto	MD Carro	oll	Fink	sburg					1 □ Yes 2 No
	ith th	Sire	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	intry?
	ath w	-ca	2012 Sandymour				1048			USA	
	er de Item	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	 Race - Amer Black, White 	
36	hours after death with the Maryland tural', or items 23a or 28a-f show all Examiner must be notified at	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:			Specify:	White
21215-0036	3 within 72 hours after death with the Marylar Jone r then "natural", or Items 23a or 28a-f show the Medical Examiner must be revilled at	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	ation		16b. Ki	nd of Business/Ir	
215	within 7, ene. then "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of d)	f working			,
		Completed	12			Homema	ker		Ow	n_Home	
pu	be filed ital Hyg id other	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mic	ldle, Maiden	Sumame)	
<u>Y</u> a		0	George Swit					zabeth			
Maryland	s 1 and 2 should f Health and Mer Item 27 Is marks other traumatic		19a. Informant's Name/Relationship (Ty)		1	ng Address (Street					
- 10	1 and Health em 27 ther tr		Charlene Kase Ne			00 Old :	Landir			rille cation - City or T	
o D	Pages nent of I int: If Its iry or o		1 Durial 2 ☐ Cremation 3 ☐ R	emovar nom State		sition (Name of natory or other place		/07/200			
Baltimore	- E E E		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licerse	Ga	rriso	n Fores	t Vete	erans C	em_C	wings	Mill, MD
Ba	permi Depa Impo eny ir		l x AC		P	Name and Addre	űnera]	l Home	and C	haspel	
7	4		23a. Pag. Enter the disease, or complic	cations that caused the deal		12 Wash: er the mode of dyin				ster,	MD 21157 Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final	11000		Buch	011- (~ 10 # A			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		tahc	10//	201	cance	(
	Examiner		O	to le	me	and	13	Cance			
Sa		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uenceo):						
	and trans	Examiner	that initiated events C	01	377						
30,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a conseq		, ,					
8760,	icate t physic s the b	dicai	d	190	9916	umine	mig				
9 x	death certifical e attending phy d for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	ancy						
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 Feta	ıl death 3□	Ectopic pregnancy Other (specify)			2	23d. Date of deliv Month	reny Day Year
P.O.		ıysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unknown	10atii 5_	Ottler (specify)			_		
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. D	id tobacco u	se contribute to t	the cause of death?
of Vital Records,	n sign	d by						1	☐Yes 2[No 3 1 ₽ 0	bably 4 □Unknown
CO	aw requir as been si 2 should	ojete						24a. W	has an	24b. Were auto	opsy findings available
Re	The lay	Completed						_ p	utopsy erformed?	prior to co death?	mpletion of cause of
ta	ysicien: The is certificate his director, page	BeC	25. Was case referred to medical				26. Place of	1 ☐ Ye		1 🗆 Yes	2L No
<u>_</u>	nysic nis ce I direc	ToE	examiner? 1 \(\text{Yes} 2 \text{PNo} \) Ho	ospital: 1 patient 2	ER/Outpatien	t 3 DOA Oth	ar	ng Home 5□R		G □Other (Speci	fy)
0	ng Ph fter th		27. Manner of Death 1 Watural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	/ at	28d. Descri	oe how injury	occurred /	
Sio	Attending Physicien: r death. ector: After this certifics by the funeral director, g	cati	2 Accident investigation				Yes 2 □ No				
Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre (y)	et, factory, office		28f. Locatio City or	n (Street and Town, State)	d Number or Run	al Route Number,
Ļ	pitel ours a erel (29a, Certifier 1 Certifying Phys	Injuny To the bear of	uulaal t :						
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Chack only 2 Medical Examin	ician: To the best of my kno le: On the basis of examina and manner stated.	wiedge, death	occurred at the time restigation, in my of	ne, date and p pinion, death o	place, and due to to occurred at the tin	ne cause(s) ne, date and	and manner as s place, and due t	stated. o the cause(s)
	ro the	Me	29b. Signature and tyle of certifier	A. A. A. A. A. A. A. A. A. A. A. A. A. A		29c. License			29d. Date	a signed (Month,	Day, Year)
)	11/		KY WCh	rela Mi)	1)-0	054	218	05.5	-(1)7-	-2007
	Mag		30. Name and address of person who cor	ppleted cause of death (Item	n_23a) (Tvpe. I	D-Control	7			4	
	4		DR. Roman 1	13 Kaneua,	319 1	nofcalv	PAI	by her	thyn	ity M.D	21157
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	4					
-	Registr	ar	MAY 0 2 21	007 Maria	K	1. 1					

		Plea	ase Type or Prin					-		•				
		For State Registrar	State of Ma	arylan		partment of F ertificate of			•	0000	10050			
2.7	8	Decedent's Name (First, Middle	le, Last)					Reg. No. 2. Date of Death 3. Time of Death						
Physicia /Medic		JOSEPH EDW	VARD HAMME	EL,	Sr.			Month MAY 1	Day 2	y Year 1007	6:10 A M			
Examin		4a. Facility Name (If not institutio	n, give street and number)			4b. City, Town, o	r Location of Death			County of Deatl				
	-Ec		EMORIAL HOSPI			FREDERIC				REDERIC				
Funeral		5. Social Security Number 6. Sex 10. Age (In yrs. last birthday) 11. Age (In yrs. last birthday) 12. Age (In yrs. last birthday) 13. Age (In yrs. last birthday) 14. Months Days Hours Min.							8. Date of Birth (Month Day, Year) Dec 2, 1921 8. Birthplace (State or Formative) Maryland					
Director		213-16-0645 Usual Residence of Decedent		Dec 2,	172	1 Har	yrand							
yland yland at		10a. State 10b. County	1	10c. Cit	y, Town or	Location					10d. Inside City Limits			
e Mar a-f sl tiffied	ctor	MD Freder	ick	Ija	msvil	1e					1 ☐ Yes 2 No			
or 28	Dire	10e. Street and Number	n 1			10f. Zip Code			-	izen of What Co	untry?			
s 23a	Funeral Director	3422 Big Woods	Road 12. Was Decedent	Ever in III	C 1	21754	lianania Origina (On	anife Van an Na	USA	14. Race - Amer	rican Indian			
ter de item	-un	11. Marital Status1 ☐ Never Married 2 ☐ Mar	Armed Forces?	No.		 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	,-	Black, White				
urs af	þ	3X Widowed 4 ☐ Divorced	If Yes, Give	1944	-46	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh:	ite				
72 ho	Completed	15. Deceder	nt's Education est grade completed)		16a. De	cedent's Usual Occup	ation during most of work	rina	16b. K	ind of Business/l	ndustry			
ithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ve kind of work done DO NOT use retired	d)	9	C+0	el Indu	2 + 10 17			
Hygie Hygie ther t	S	12 17. Father's Name (First, Middle,	Last)		ratt	ern Maker	18. Mother's Nam	e (First Middle	L		5C1 y			
d be f ental l ced or	o Be	Joseph Meredith	•					ry Storch						
shoul and Mi	ဥ	19a. Informant's Name/Relations	ship (Type. Print)		19b. Ma	ailing Address (Street	and Number or Rui	al Route Numb	er, City o	or Town, State, Z	ip Code)			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inimportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Elizabeth Hamme	el Hernandez/				Woods Rd	. Ijams	VIII	e, MD 2.	1/54			
Jes 1 t of He If iten		20a. Method of Disposition 1 ☐ Burial 2 【X remation	3 □Removal from State	0	emetery, c	position (Name of rematory or other place	ce)	Date		ocation - City or	· ·			
t. Pag tmen tant: njury		4 Donation 5 Other (5	Specify)	Ch		ake Cremat				sville,				
permi Depar Impor any Ir	П	21. Signature of Funeral Service	Lidensee	140.1		Going Home								
		23a. Part1. Enter the disease, o	or complications that caused	MO 1 d the deat						arksvil	Le, MD 21029 Approximate Interval Between			
Physician		shock, or heart failure. List	t only one cause on each li	ne.	an maria Arrana	1.					Onset and Death			
/Medical		disease or condition resulting in death)	a. Due to (or as	a onseq		e near	roul	Tre-			2 Days			
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be executed cian and ourial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):									
	_		d											
The law requires that the death certificate be the has been signed by the attending physici bage 2 should be detached for use as the bu	Physician/Medica	IS SERVICE.												
ith cer tendir ir use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			3 □Ectopic pregnancy	/			23d. Date of deli				
ne dea the at	/sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ He past 12 months? 4 □ Pregnant at time of death 5 □ Other (specify)								Month Day Year				
that the											bacco use contribute to the cause of death?			
w requires that the de been signed by the should be detached	d by	Documan	ia					10	Yes 2	2No 3 Probably 4 Unknown				
w rec	lete								24a. Was an 24b. Were autopsy findings ava					
The lav ite has	Completed	1								prior to completion of cause of death?				
tlan: ertifica ctor, p	BeC	25. Was case referred to medical 26. Place of Death (Check only one)												
hysle this ca	2	examiner? 1 Yes No												
Jing F After funera	ion:	27. Manner of Death Natural 5 Pendir		iry iy Year)	28b. Time Injur	y Wor	yat k? Yes 2 ⊡No	28d. Describe	how inju	ry occurred				
Attending Physician: r death. ector: After this certific: by the funeral director,	ficat	2 Accident investi	not be 28e. Place of injuried	ury - At ho	me, farm,	street, factory, office	163 2 NO	28f. Location (Street an	nd Number or Ru	ral Route Number,			
al or / s after al Dire	Certification:	4 Homicide determ	building, et	tc. (Specif	y)			City or To	wn, State	=)				
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?		29a. Certifier 1 Certifyii	ng Physician: To the best I Examiner: On the basis o	of my kno	włedge, de	eath occurred at the tir	me, date and place,	and due to the	cause(s) and manner as	stated.			
the F thin 24 the F mplet	Medical	29b. Signature and title of certific	and manner sta			29c. Licens				te signed (Mont				
T wit		298. Signature and title of certifie	1 1	1 =	, .) - LICENS	1 (1 . 2		290. Da	te signed (Mont	i, Day, Fear)			
JM		30. Name and address of person	who completed cause of c	death (Item	104 123a) (Typ	e, Print)	1043		7	107				
71		650	Thomas	J	hours	ap 88	Frede	sick	1	nD 21.	702			
Sta	- 3	31. Date filed (Month, Day, Year,	32. Redistr	ar's Signa	ture			-						
Registr		MAY U	4 (007)	sec.	D.	goods								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ruby Naomi Hudson May 02 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10329 Germantown Road Berlin Worcester If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 3 F Months Min. Director 169-34-8247 65 Jan 25, 1942 MD Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 show Examiner must be notified at 1.☐Yes 2☐No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10329 Germantown Road "natural", or Items 23a 21811 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Š 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiene. Importent: if Item 27 is marked other that any pincy or other traumatic event, Item 2008. 12 Housekeeper Motel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Bennett ပ Naomi Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Hudson/daughter 10329 Germantown Road, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul UMC Cem 5/7/2007 Berlin, MD 22. Name and Address of Facility
Lewis N. Watson Funeral Home 21. Signature of Funeral Service License Idlask 12 Walter 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metostatic Corcinoma of the right breast **Physician** 3 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the purial-tr Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Š signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 21 No To the Hospitel or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: A 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D D0014314 town 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll stut, Solisbuy, m. D. 21804 KLUG. PANPIT P. 145 E 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Asidence of Decedent 10b. County 10b. County 10b. PRINCE 10b. County 10b. Coun	JENKINS a street and number) IGTON HOSP. EX	birthday) Yrs. If Under Months FORT WAS 10f. Zip 13. Was Decedent's Usua (Give kind of wor life. DO NOT us HEAVY Editor of Disposition (Nane)	SHINGTON Code 20744 Jent of Hispanic Origin? Introduction, Mexican, Puer of Mexican, Pu	Specify Yes or No- (Specify Yes or No-	Day Year 2007 4c. County of Death PRINCE GI 9. Birthp Cour MD. 1942 Dg. Citizen of What Cour U.S.A. 14. Race - Americ Black, White, Specify: WH. 16b. Kind of Business/Inc.	olace (State or Foreigner) 10d. Inside City Limit 1 □ Yes 2X N ntry? can Indian, etc. ITE dustry					
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or's Name (First, Middle, Last) DONNIE JENKI Domant's Name/Relationship (7 MARY A.JENKI hod of Disposition Burial 2 1 cremation 3 Donation 5 Other (Specify	INS Type, Print) INS-SPOUSE 20b. Place ceme	19b. Mailing Address 9505 ALL a of Disposition (Nan	18. Mother's N RUB (Street and Number or I	ame (First, Middle, M							
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20a. Method of Disposition 1											
nt1. Enter the disease, or compock, or heart failure. List only of the Cause (Final or condition in death) ially list conditions, addition to immediate enter Undertying Disease or injury lated events in death) Last	Disease	Approximate Interval Betweer Onset and Deat									
ALE: s decedent pregnant he past 12 months? Yes 2 \sumbed No] Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of delive Month	f delivery Day Year							
ther significant conditions co	ontributing to death but not resultin		bacco use contribute to the cause of death? es 2 □ No 3 ☑ Probably 4 □Unknow								
		opsy prior to completion of cause of death?									
case referred to medical niner? Yes 2 \(\sum \text{No}\)	eath (Check only one Home 5 - Reside	only one) Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Colud not be determined. 28a. Date of Injury 28b. Time of North, Day Year) 28b. Time of Unitry 28b. Time of North, Day Year) 28b. Time of North, Day Year) 28b. Time of North, Day Year) 28b. Time of North, Day Year) 28c. Injury at Work? M 1 Yes 2 No 28c. Cloud not be determined.											
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rtifier 1 Certifying Ph	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Date of Certifier) 29d. Date signed (Month, Date of Certifier)										
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. 15	Physici	an	1. Decedent's Name (First, Middle, Last)	Day Year	3. Time of Death								
*	/Medic	_	Clarence Jac 4a. Facility Name (If not institution, give st		-	4b. City,	Town, or Loca	ition of Death	May 8,	4c. County of Dea	3:15p ^M		
S. 20	Examin	er	Laurelwood Care			Elkton				Cecil			
	Funeral Director	1	5. Social Security Number 6. Sex 218-32-0091	^{9. Bio} 29,1931	thplace (State or Foreign ountry) MD								
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits		
	Maryii ied a	tor	MD Cecil		E1kto	n					1⊠Yes 2 No		
	n 28a	Director	10e. Street and Number		22.1100	10f. Zir	Code			10g. Citizen of What C	ountry?		
	23a c		100 Laurel Dr.				1921			U.S.A.			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mential Hygiene. Item 27 is marked other than "natural; or Itams 23s or 28s-1 show other traumatle event, the Medical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		dent of Hispani cify Cuban, Me 2 □X No <i>Sp</i> o		ecity Yes or No- Rican, etc.)					
ς Ω	72 ho	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	(Give	kind of wo	al Occupation	most of work	ing	16b. Kind of Business	/Industry		
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р Б	filed v Hygie other t		17. Father's Name (First, Middle, Last)	_	ьар	orer		Mother's Name	e (First, Middle,	Maiden Sumame)	CIOII		
au	ld be ental ked o	To Be	John Jackson	ailab1	.ab1e								
ary	2 should and Men is marke aumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z.											
	and 2 ealth m 27 i		Charles Jackson										
Baltimore,	Pages 1 nent of H ant: if Ite ary or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, cre	matory`or	other place)		0,2007	20c. Location - City of			
Ē			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Further Service License		A. Fe		Inc.	Facility		West Che	ster, PA		
Ba	permit. Departr Importa any inj		KHAO		A:	ndre	w G. (Gee Fu	neral				
			259 E. Main St., Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
1	Physician		Immediate Cause (Final disease or condition										
	/Medical Examiner		resulting in death)										
Ш		Jé.	So quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Cera (Mon. of Aug. Cera) Coulon (Initiated events) C. Cera (Mon. of Aug. Cera)										
	uted 1 ansit	Examiner											
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x 68	that the death certifical ed by the attending phi detached for use as th	Mec	IF FEMALE:	lc. If yes, outcome of pregna		23d. Date of delivery							
Вох	attend for us	cian	in the past 12 months?	23d. Date of de Month									
P.O.	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown										
Vital Records, P	The law requires that the death certifica tie has been signed by the attending ph rage 2 should be detached for use as th	ed by Physician/Med	Part II. Other significant conditions cont	obacco use contribute res 2 🗆 No 3 🗀 F	-								
၀၁	e law re has bee ge 2 sho	Completed			24b. Were autopsy findings available prior to completion of cause of								
Œ.	The cate h	Com				perfor	performed? death?						
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:			10000		Death (Check only one)				
ō	Phys r this ral dir	1. To	1 Yes 2 No	28a. Date of Injury	28b. Time of Injury		28c. Injury at	Nursing Ho		lence 6 Other (Sp.	ecify)		
on	nding ath. r: Afte e fune	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	м	Work? 1 ☐ Yes	2 🗆 No						
Division of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		reet, factor	y, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	he Hospil n 24 hour ne Funera	Medical (29a. Certifier 1 / Certifying Physical (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred ivestigation	at the time, dan, in my opinion	ate and place, n, death occur	and due to the dired at the time, d	cause(s) and manner a date and place, and du	us stated. e to the cause(s)		
	29b. Signature and title of certifier 29c. License number 29d. Date									29d. Date signed (Mor	-		
•			I Am cesi War				DO 41	013		5/11/	0 7		
			30. Name and address of person who cor				£1	14/00.	mo	21921			
	Sta	ite	31. Date filed (Month, Day, Year)	Registrar's Signa	iture	-				•			
	Registi	ar	MAY 1 7 200	7 Miles Ja	· A	Mary I							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** PM 2007 8:09 Inez Wilhemina Johnson April 27, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F 74 Yrs. 578-50-7624 Director Washington, D.C 10/07/1932 Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or iteme 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Directo Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 11646 Drumcastle Terrace 20816 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify Black Completed by 3 TWidowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Housekeeper Private Residential 8 pernit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: if item 27 is marked other to any njury or other traumatic event, Impage. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernice Harris William Woods ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Dempsey/Daughter 11646 Drumcastle Terrace Germantown, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery | 05/03/2007 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 23a. Parl 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis Weeks /Medical Due to (or as a consequence of): Examiner Weeks Pneumonia Sequentially list conditions, flary leading to in reciale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown Completed Urinary Tract Infection 24b. Were autopsy findings available prior to completion of cause of death? Sacral decubitus ulcer 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Respiratory Failure 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one P P Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No i Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours after the funeral Discompletely filled in Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Ë 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number work Mp D32332 April 30, 2007 Name and addre is of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, MD 9801 Georgia Avenue Suite 220 Silver Spring, MD Date filed (Month, Day, Year)
MAY 0 3 2007 32. Registrar's Signature State Registrar D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2007 4:20 A M **Physician** KWOK 30 April KWEI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Cit Hospital HOPKINS The Johns Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 💥 F OCT 19,1942 CHINA 561-66-9396 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at 1∏Yes 2∏No Director Glenn Dale MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20769 12603 Chalice Ct death v by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 **▼**No Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2127 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Chinese Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Senior Citizens Home Patient Account Representive permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event, the jance. 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Choi Ying Woo Fat Seto ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31 Tamarack Drive, Woodcliff Lake, NJ 07677 Corinna Kwok Wong/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rockville, Md 5-3-07 Parklawn Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility oseph Gawler's Sons, INC 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years metastatic uterine cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Dunknown nis certificate has been signed by director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? (es 2 No death? 1 ☐ Yes 2□ No 1□ 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2X No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Injury After (Month, Day Year) 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. thours after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Directory filled in by the 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 24

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

CI DURAND MEDICAL DOCTOR

Christine Durand, The Johns Hopkins Hospital, 600 North Wolfe Street,

38. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 3 2007

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

April 30, 2007

Maryland 21287

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 27 2007 3:05 A FREDERICK WILBURN KRAUSE April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 807 Midland Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Year) 1 X M 2 □ F 85 1921 California Nov. 11. 549.38.6325 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at ORGE. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A. 20904 807 Midland Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No WW II If Yes, Give Year or Dates: 1 Never Married 2 Married _{Specify:} White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education School Teacher 5+ years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorena Fisher Krause Frederick P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 801 Midland Road, Silver Spring, Maryland 20904 Derris Krause/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 05/03/2007 Silver Spring, MD Gate of Heaven Ceme. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licer see 22 Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy the death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has le 2 autopsy page perform certificate 2⊠ No Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 Inpatient ို After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🖾 Naturai .al or Atternative after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 1, 2007 D0064615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, MD, 1355 Piccard Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

03

MAY

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Catherine Month 2007 **Physician** 1:05 P M Kidwe11 Mary May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Bayside Care Center Lexington Park If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F 577-20-9954 87 Virginia **Director** December 3, 1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits St. Mary's Mechanicsville Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 26936 Cavalier Street 20659 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 □ Yes 2 🖔 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**₹** No White 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Administrator Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert James Sowers Margaret Edward Wilson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26936 Cavalier Street, Mechanicsville, MD 20659 Margaret Brady / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 9, 2007 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ceder Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 Leonardtown, MD 20650 Michael Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deal Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician 24 /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2□ No 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 🔲 Inpatient 1 ☐ Yes 2 B No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

hysician and the burial-transit as use as been signed by the atte 2 should be detached for page funeral director,

The law requires that the death certificate be executed

or Attending Physician:

After

death.

after death

within 24 hours a

To the Funeral I

completely filled

filled in by

Medical

physician

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1

Baltimore, Maryland 21215-0036

r 28a-f show notified at

Certification: To

27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

(Check only

6 Could not be determined

28a. Date of Injury (Month, Day Year) Injury

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D. 24035 Three Notch Road Hollywood, MD 20636

State Registrar

31. Date filed (Month, Day, Year) MAY 0 8 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** E 621 04 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 □ Months Days Hours 100 013-01-6640 Aug. 26, 1906 Massachusetts Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Annapolis 1 ☐ Yes 2xxxVo Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21401 4000 River Crescent Drive Completed by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No 1 ☐ Yes 2√2√No Specify. White Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry Ith and Mental Hygiene. It is marked other than "nature traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delia Sullivan permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev George Rowe မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1514 Knollwood Place Annapolis, Maryland 21409 Arthur Libby/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory 5/1/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician psi disease or condition resulting in death) Due to (of as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and I-transit Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | d be det ð 2 💢 No 1 🗌 Yes 3 Probably 4 Unknown leted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Compl cate has l page 2 s perform 2□ No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3□ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death 28b. Time of After Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760, 0 ۵. or Vital Records, Hospital or Attending Physician: Division

this certificate

ould be filed within 72 hours after death with the Maryland Mental Hygiene.

"natural",

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director; Af within 24 hours a Medical By

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) MM.

29c. License number

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
MAY 0 1 2007

29a. Certifier

(Check only one)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, LTEM#2.perPHYS..G867.5/25/07.WS......

AMEND, ITEM#2, perPHYS, G867, 5/25/07 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. $\frac{20}{20}$ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 2007 Physician Elmer Leroy Lease 3:30P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Civista Medical Center La Plata Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 9, 1924 9. Birthplace (State or Foreign 5. Social Security Number 6 SAY 7. Age (In yrs. last birthday) **Funeral** Mary Land 1**∑**IM 2□ F 221-28-8108 82 Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or iteme 23s or 28s-f show the Medical Exertines must be notified at 1 ☐ Yes 2 ☑ No St. Mary's Charlotte Hall Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29449 Charlotte Hall Road 20622 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ģ White 3 Widowed 4 Divorced naturei Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) US Govt. Carpenter permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Important: If Item 27 ie marked other it eny injury or other traumatic event, Ita once. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Mattia/Friend 29449 Charlotte Hall Rd. Charlotte Hall,MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ↑ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 5/1/2007 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facil BRINSFIELD ECHOLS FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Aspiration/Pneumonia /Medical Due to (or as a consequence of): Examiner Cerbravascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Atrial Fibrillation, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown is certificete has been si director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 1 ☐ Yes 2□ No 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending Injury s effer dec. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 4, 2007 D-61616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2007

2. Registrar's Signature

Ravinder Sindhwani, M.D. 11350 Pembrooke Square, Suite 304, Waldorf, MD 20603

07-03430

Mr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Denise Lightning Certificate of Death Reg. No. 1- For State 3. Time of Death 2 Date of Death Registrar

1. Decedent's Name (First, Middle,Last) Month Day May 5, 2007 0435 hrs Physician/ DENISE LIGHTNING <u> Examiner</u> c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Foreign Country) Wash., DC 5. Social Security Number Min Funeral Months Hours 12-27-1959 Director M 2 - 34-F 579-86-9780 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 1 ¥Yes 2 No Forestville Maryland Prince George's 23a or 28a-f show notified at once. 10g. Citizen of What Country? the Maryland Director 10f. Zip Code 10e. Street and Number USA 20747 5503 Marlboro Pike Apt. 7 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 11. Marital Status Armed Forces? 1 *Never Married 2 Married 2[₩] No Yes **Black** Yes 2 * No specify: If Yes, Give Yeer Divorced 3 Widowed 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) filed within 72 hours Completed Private Industry College (1-4 or 5+) Elementary/Secondary (0-12) other than "r HouseKeeping 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Lewis Baltimore, MD 21215 permit. Pages 1 and 2 should be files Department of Health and Mental Hy Important: If item 27 is marked o injury or other transmatic event, the Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 Lloyd Lightning 5503 Marlboro Pk. Forestville, Md. 20747 19a. Informant's Name/Relationship (Type, Print) ဥ Tanjanickia Lightning/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 5-08-07 20a. Method of Disposition crematory or other place) Burial 2 🔀 Cremation 3 Removal from State Riverdale, Md. Riverdale Park Crematory Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee Cedar Hill FH 4111 PA Ave. Suitland, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and nysician Death failure. List only one cause on each line. Medical a Exacerbation of congestive heart failure Immediate Cause (Final disease _xaminer Due to (or as a consequence of): or condition resulting in death) dilated cardiomyopathy Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause chronic drug usage (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED #23a-c.27.perME, g867, 5/29/07 TI signed by the attending physician be detached for use as the burial 23d, Date of delivery 23c. If yes, outcome of pregnancy Box 68760, Year IF FFMALE: Month Day Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, P.O. ģ 24b. Were autopsy findings available 24a, Was an Completed prior to completion of cause of has been page 2 should autopsy performed? death? 2 No Yes 2 ✔ No certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Nursing Home 5 Residence 6 Other: Be Other: Hospital: 1 Inpatient 2 V ER/Outpatient DOA examiner? 1 V Yes No 28d. Describe how injury occurred this ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury funeral 27. Manner of Death After Certification: 1 Yes 2 No 1 X Natural 5 Pending 24 hours after death. Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 6 Could not be 3 Suicide within 24 hours and To the Funeral Di determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 1 Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 6, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1,2007 12:51P M SUP WON LEE MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSP ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. AUG. 7, 1 9. Birthplace (State or Foreign Country) S KOREA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F Months 63 280 72 6105 ,1943 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10h. County 10d. Inside City Limits POTOMAC 1 ☐ Yes 2 ☐ No MD MONTGOMERY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 14648 ROLLING GREEN WAY 20878 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**Vo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify þ Specify: ASIAN 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS ENTREPRENEUR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOON KWANG LEE LEE SANG MOOK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Healt Important: If item 27 any injury or other tra 14648 ROLLING GREEN WAY POTOMAC MD 20878 LEE /SON ROBERT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA METROPOLITIAN 5/3/7 21. Signature of Fyneral S 22. Name and Address of Facility CHARLES HINDS FUNERAL SERVICE ce Licensee MARLBORO MD 20772 12303 KAYAK DR UPPER 23a. Part1. Enter the dise shock, or heart failure. se, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ary though minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the buriat-trans Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Honknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours a P Funeral I

completely within 24

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

-01-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AARON SNYDER MD 9901 MEDICAL CTR DR ROCKVILLE MD

20850

31. Date filed (Month, Day, Year) MAY 03 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MAY 6,2007 3:55P ELLIS LEON MACE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE FORT WASHINGTOn FORT WASHINGTON HOSP. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ₹ M 2 □ F 71 7-27-1935 MD. 579-46-8893 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itema 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 🏖 ☐ No MD. PRINCE GEORGE ACCOKEEK Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20607 U.S.A. 15941 LIVINGSTON ROAD death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ¬Yes 2 □ No If Yes, Give △ P M V 11. Marital Status filed within 72 hours after 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: ARMY þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) STONE/MARBLE College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiane. UNION LOCAL 2 STONE/MARBLE MASON 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of þ permit. Pages 1 end 2 should be Depertment of Health end Mental Important: If Item 27 is marked any Injury or other traumatic events. ပ္ CLARENCE LEW MACE HELEN LOVELESS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15941 LIVINGSTON RD. ACCOKEEK, MD. 20607 VERNA MACE-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD. VETS. CEM. 5-14-07 CHELTENHAM, MD. RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Fyneral Service Licensee MOO\$79 LA PLATA, MD. 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arkny Wordy /Medical Due to (or as a consequence of): **Examiner** hyperten Szon Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day sate has been signed by the ette pege 2 should be detached for 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 26 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2DER/Outpatient 3DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death t - Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours efter death To the Funeral Director: completaly filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 12 Certifying Physician: To the best of my knowledge, death uccurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier El Physicer @~~ ~ DCO57632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XI wagstun Rd. Ff Washraptun I ames Mitabell and 117116 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

7 2007

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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At building, etc. (Spec												al Route Number,						
	ne Hospita 24 hours ne Funera detely fille	Medical C	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physic Examine	er: On the	ne best of basis of nner sta	examinati	vledge, deat ion and/or in	h occurre	ed at the tir on, in my o	ne, date a ppinion, de	and place, a	and due to t ed at the tim	ne cause ne, date a	(s) and manr and place, an	ner as s d due t	stated. o the cause(s)			
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Constance Ruth Merendino 2007 11:40 A M MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Dave Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months December 1,1948 Washington, DC 577-66-6503 58 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. 71 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland St. Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22930 Connie's Way 20618 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis L. Wheeler, Sr. Marguerite Daras 19a. Informant's Name/Relationship (Type. Print)
Lisa Merendino/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22930 Connie's Way, Bushwood, MD 20618 permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Trinity Memorial Gardens 5/10/07 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ellers " Ent 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., tyre of Funeral Septe Licens 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List orly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1erminal Physician lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respirator Sequentially list conditions, if arry, leading to influed accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) attending physician for use as the burial Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform this certificate 26. Place of Death (Check only one)

Be Medical Certification: To

funeral

filled in by

after death

within 24 hours a

To the Funeral

25. Was case referred to medical examiner? 1 ☐ Yes 2 No Manner of Death

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

(Month, Day Year) 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

470G6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVANI D. SHAH M.D. PO BOX 404 LEONARDTOWN, MD 20650 31. Date filed (Month, Day Year)

State Registrar 32 Registrar's Signature

CONSTANCE MERENDINO

Division or Attending

			1 - For Stete Registrer	State	of Marylai	•	artmen rtificat			nd M		giene Reg. No.	007	16073
	Dhusisi		1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		ALBERTA BADO	UD MILLS							APRIL	21	2007	2:43 AM M
	Examir	ner	4a. Facility Name (If not institutio	_			4b. City,	Town, or	Location of				unty of Death FALBOT	
			GENESIS HEALTH 5. Social Security Number	6. Sex	7. Age (In yrs	last birthday)	If Under	r 1 Year	EASTO		8 Date of Birtl			place (State or Foreign
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yland	m C 0 /	70	VINCENT BADO	UD					M	IAY 1	RYDER			
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	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):	//-	0. 1						w
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	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	(Or as a conse	daeuce oil								
<u>_</u>	be executicien and burial-tran	Exar	that initiated events resulting in death) Last	C. Due to	(or as a conse	quence ol):								
0/2 0/2	icate be executed physicien and s the burial-transit	dlcal		d										
٥	death certificate e attending phys d for use as the	Med	IF FEMALE:	T									-	
۵ و	ieath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr birth 2 ☐ Fet Inant at time of	al death 3	Ectopic p					23d.	Date of delive	very Day Year
j.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		death 5	Other (sp	эөспу)						
<u>τ</u>	w requires thet the di been signed by the should be detached	by Ph	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying o	ause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
cords	requires thet een signed b nould be deta	ed b	pronchied	all							1 🗆 Y	es 250	o 3□Pro	bably 4 Unknown
ပ္သ	law re as bee	Completed									24a. Was autop	an 2	4b. Were aut	opsy lindings available ompletion of cause of
Ÿ,	sicien: The law s certificate has b irector, page 2 st	E									pertor	med?	death?	2 □ No
VII	cien: ertific	Be (25. Was case referred to medica examiner?					1		of Death	Check only of	ne)		
5	Physicien: this certific ral director,	은	1 Yes 2 No 27. Manner of Death		-	ER/Outpatien			4 L Murs		ne 5 Resid			rfy)
	ding h. After tuner	tlon	1 Natural 5 ☐ Pendi	ng (Mo	of Injury oth, Day Year)	Injury	M	28c. Injury Work	rat t? Yes 2.∐N		8d. Describe h	ow injury oc	xurred	
UNISION	Atten r deal octor:	flca	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At I	nome, farm, str							umber or Rui	ral Route Number,
5	spital or Attending Physicien: ours after death. harel Director: After this certific filled in by the funeral director.	Certification:	4 Homicide	Dulk	aing, etc. (Spec	ity)					City or Tow	m, State)		
	To the Hospital or Attending within 24 hours after death. To the Funarel Director: After completely filled in by the fune	edical	29a. Certifier Certifyi (Check only one)	ng Physician: To th Examiner: On the and ma	e best of my kn basis of examin nner stated.	owledge, death ation and/or in	n upnumed vestigation	at the time,	e data and pinion, death	place, a occurre	indiduction the ded at the time, o	ause(s) and date and pla	t manner as	stated to the cause(s)
	Vithin 24 h	Me	29b. Signature and title of certifie	or Make			290	c. License	number		1		gned (Month	
and the same	5		,)	MAS / M	D			125	155			4	. 29.0	H
	LP		30. Name and address of person	V C I W	0 0	-	,	-0.0	: 1	2.1./	<i>I</i> -	Acto	, mr	3 21601
1	CI		31. Date filed (Month, Day, Year	30011124 1	Registrar's Sign		JTCHI	חלוויו	ント	JNE		Olci	N LIK	1 011001
	Sta Registr				House		hour	ر ا						

ORIGINAL

Division or Vital Records, P.O. Box 68760,

State Registrar KENNEDY

31. Date filed (Month, Day, Year) APR 2 5 2007

22

5

GREEN ST.

Registrar's Signature

BAITIMORE, MD. 21201

			ricase	Chata of Manuford /			-		
			For State	State of Maryland / [Department of Ho			21111	16075
			Ragistrar 1. Decedent's Name (First, Middle, Las	21)	Certificate of L		Reg 2. Date of Death	J. No 0 0 /	3. Time of Death
	Physici	an	Warner Willis N				Month	Day Yeer 2007	11:15A M
	/Medio		4a. Facility Name (If not institution, give		4b. City. Town, or	Location of Death	riay J,	4c. County of Death	11.1311
	Examir	ler	Charlotte Hall Ve		Charlot			St. Mary's	S
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. last bir	thday) If Under 1 Year		8. Date of Birth (Month, Day, Y		lace (State or Foreign
:	Director		127-18-3642	7 M 2 □ F 80	Yrs. Months Days	Hours Min.	November	1,1926 N	ew York
	pu 🔉		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location			1	0d. Inside City Limits
	ehov	'n						,	1 ☐ Yes X2 ☐ No
	the M	ect	Maryland St. Mai	ry's Ch	arlotte Hall		100	. Citizen of What Cour	
	within 72 hours after death with the Maryland ane. then "naturel; or iteme 23a or 28a-f ehow ha Madical Examinar must be notified at	by Funeral Director	29449 Charlotte H	Hall Rd	2062	2		S A	10 y 2
	leath	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of His If Yes, specify Cubar			14. Race - Americ	an Indian,
(0	ritter of	Fun	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No			lican, etc.)	Black, White,	
21215-0036	er's a	þ	3 ☐ Widowed 4 ¥☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo	Specify:		Specify: Wh:	ite
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest grad	ducation 16a.	Decedent's Usual Occupa	tion uring most of working	16	6b. Kind of Business/Inc	dustry
21	ithin see	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done di life. DO NOT use retired)		1		
	Hygier ther the	ဒ	12 17. Father's Name (First, Middle, Last)		erk	18. Mother's Name		ederal Gov	ernment
anc	ould be fi Mental H mrked ot atic ever	Be	Edward McClelland			Gladys		duen Suname,	
Maryland	hould d Men marke	ှင	19a. Informant's Name/Relationship (7		o. Mailing Address (Street a			City or Town State Zin	Cade
Σ	d 2 sho		Bonnie McClelland	/D 11	3113 Wonderla				
ē,	iges 1 and 2 should be filed within 72 hours after death with the Maryiar to Health and Mental Hygiene. If item 27 is marked other then "naturel; or iteme 23a or 28s-1 ehow or other treumatic event, the Madical Examinar must be notified at		20a. Method of Disposition	20b. Place o	f Disposition (Name of	Da	ite 20	c. Location - City or To	
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		1 Burial 2 Tremation 3 4 Donation 5 Other (Specify	Removal from State Brins:	f Disposition (Name of ry, crematory or other place field-Echols	"Crem. May	$\frac{7}{3}$, CI	harlotte Ha	11. MD
Ħ	permit. Pa Departmen Importent: eny injury		21. Signature of Funeral Service Licen	<u> </u>			JU /	chols F.H.,	
ñ	Departicular Depar		Dante O.	a 1 1 M75064	6 30195 Three	e Norch Ro	lCharle	otte Hall	MD 20622
			23a. Part1. Ent of the disease, or composhock, or hand failure. List only of	plications that caused the death. Do					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ARNIAC	DOPIL	77-11111/	2	1	Onset and Death
7	/Medical		resulting in death)	a. Due to (or as a consequence	of): 17 199	174111			
	Examiner		Conventially liet and distance	· CHRDINER	ESPIRATO	RY FI	AKIK.	6	
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	6f):		Λ.	,	
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. CHEONIC	UBSTRUCT	VELI).	NG 1/1	I AYE	
760,	ate be executed nysicien and he burial-transit		resulting in death) Last	Due to (or as a consequence	of): /				
687	cate b	dicai	•	d					
9 x	ding y	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy					
Вох	aath c	lan	in the past 12 months?	1 Live birth 2 Fetel death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
	the de	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown	5 Utilei (specify)				
P.O.	The jaw requires that the death certifical ate has been signed by the ettending phypage 2 should be detached for use as the		Part II. Other significant conditions co	ontributing to death but not resulting in	n the underlying cause give	n in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ds.	uires sign	d by					1 Yes	2 No 3 Prob	ably 4 Unknown
00	w require been si should I	Completed					24a. Was an	24b. Were auto	psy findings available
Re	he ia e has age 2	Ĕ					autopsy	prior to con death?	impletion of cause of
ta	an: T tificat tor. pa	as I	25. Was case referred to medical			26. Place of Death		ZNo 1 ☐ Yes	2U No
Division of Vital Records,	Physician: The iaw this certificate has trail director, page 2 s	ToB	examiner?	Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Othe			ce 6 KOther (Specific	11501000
0	ng Phys ter this neral di		27. Manner of Death		Time of 28c. Injury lnjury Work		Bd. Describe how		1110
Ö	Attending r death. ector: After by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation			es 2□No			
Ĭ.	r Atte	titic	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa	arm, street, factory, office	21	Bf. Location (Stre	et and Number or Rura State)	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director; After thi completely filled in by the funeral.								
	Hoep 4 hou Fune ely fil	cai	(Check only 2 Medical Exam	ysician: To the best of my knowledge niner: On the basis of examination ar	e, death occurred at the time nd/or investigation, in my op	e, date and place, ar inion, death occurred	nd due to the cau d at the time, date	se(s) and manner as si e and place, and due to	tated. the cause(s)
	the the mplet	Medicai	29b. Signature and title of certifier	and manner stated.	29c. License			I. Date signed (Month,	
	N Will		255. Signature and title of certifier	t \	230. Elcense	0 4 /	290	Jalo signed (Month,	wwy, rodij
7	(X				1 1 1 2	406		>13/0	7
X	C/X)		Dr. Louis Kaufma	completed cause of death (Item 23a) an,12070 01d Lin	(Type, Print) Le Centre, #2	07. Waldo	rf. MD 2	0602	
	Sta	to.	31. Date filed (Month, Day, Year)	2. Registrar's Signature	#	-, marao	, IIV Z	0002	
	Pegiete		MAY 0 7 200	7 60 1 10	Smarth a				

07-03393 Britia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 16076

any Mercer	1-	- For State Criticate of	Death	Reg. No	lo Time of Dooth				
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death Year 2105 hrs				
Examin		Britiany Mercer		May 3, 2007	c. County of Death				
	4	4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of Death						
		University Hospital	Baltimore If Under 1 Year If Under 24Hrs	8 Date of Birth/MM	Baltimore W/DD/YYYY) 9. Birthplace (State or				
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		Foreign				
Director	- 1	$212-25-8937$ $1_{1 \text{ M}} 2^{\text{K}}_{\text{F}}$ 17 Yrs	1010111110	June 1, 1	.989 County/Maryrand				
	h	Usual Residence of Decedent			10d. Inside City Limits				
any		10a. State 10b. County 10c. City, Town or Locat			1 Yes 2 Y No				
*		Maryland St. Mary's Californ		1400.0	Citizen of What Country?				
arylai 8a-f	发	10e. Street and Number	10f. Zip Code 20619	Tog. c	USA				
sath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	45960 Shields Ct.			14. Race - American Indian, Black,				
with 1 18 23.	<u>a</u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 15.	as Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.				
r item	Funeral	1 Never Married 2 Married 1 Yes 2 No	Yes 2 No specify:		Specify: White				
ifter o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify. nt's Usual Occupation (Give kind of	work done 16	b. Kind of Business/Industry				
ours a	힣	15. Decedent's Education (openity only manner and during n	nost of working life. DO NOT use re	tired)					
72 h	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Stud	ent	(Calvert High School				
O3(Ē		18.Mother's Nam	ne (First, Middle, Maid	en Surname)				
5-0 iled v Hygi	ပ	17. Father's Name (First, Middle, Last) Harrison Rodney Mercer	Shelli	e Marie Sl	numaker				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or	Rural Route Number	, City or Town, State, Zip Code)				
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shu umaite event, the Medical Examiner must be notified at once	۲		O Shields Ct., C	California	MD 20619				
MD and 2 sho salth and 2 sho em 27 is		20h Place of Dispo	osition (Name of cemetery,	May 9,	Dc. Location - City or Town, State				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death Department of Health and Merlal Hygiene. Important: If item 27 is marked other than "natural", or iter injury or other traumatic event, the Medical Examiner must.		1 X Burial 2 Cremation 3 Removal from State Trinity	emorial Gardens	2007	Waldorf, MD				
Pag ment tant:		4 Donation 5 Other Specify:			Echols F.H., P.A.,				
Salt ermit Separt mpor njury		21. Signature of Fulleran Service Electrics	0105 Three Notch	Rd Cha	rlotte Hall, MD 20622				
		Approximate interval as Part Legislations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near approximate interval as Part Legislations and a Part Legislation and a Part Le							
ysician ./ledical		failure. List only one cause on each line.							
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Immediate Cause (Final disease a. Multiple Injuries						
		b.							
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	(Disease or injury that initiated Due to (or as a consequence of):							
ed	Exa	events resulting in death) Last d.							
xecul m and l - tra	<u>8</u>	UNPENDED AMENDED							
60, ate be executed physician and ne burial - transit	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		- The	23d. Date of delivery Month Day Year				
876 tiffical ng ph			Fetal death 3 Ectopic pre	gnancy	Month Bay				
O. Box 687 that the death certific need by the attending personned by the attending personned for use as if	Physician/	past 12 months / 4 Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)						
Bo te dea the a	غ ا	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		acco use contribute to the cause of death?				
P.O. es that the igned by	ğ			1 Yes	2 No 3 Probably 4 Unknown				
ords, P.C. w requires that s been signed				24a. Was ar					
ord w req	<u>e</u>			autops perform	ned? death?				
Che la	Completed		26.Place of Death (Ch	1 Yes 2	140 1 100 1				
Division of Vital Records, tal or Attending Physician: The law requints after death. The The this certificate has been so a burgetor. After this certificate has been so a burgetor. A consert director names of should be	Be C	25. Was case referred to medical	Other:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Residence 6 Other:				
Vit hysici this o	T G	O 1 ✓ Yes 2 No	Tellt 3 DOA	28d Describe h	ow injury occurred				
of Vi	2 1			Driver auto a	uto collision				
ion tendi	igi igi	1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm,	street factory office building, etc.	28f, Location (S	treet and Number or Rural Route Number, City				
ViS or At fter d	in of	3 Suicide 6 Could not be 28e. Place of Injury - At nome, larm,		or Town, St Southbound R	ate) t. 5, Waldorf , MD				
pital Di	E E	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) Major Road / High	vay						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and			stigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)				
To th	duo	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)				
	2	29b. Signature and title of certifier	O.C.M.E.		May 4, 2007				
		TIMEN							
Va	1111	30. Name and address of person who commetted cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111	Penn Street, Baltimore, Mi	21201					
- W		Susail Hogari W.B.	4						
Day	Sta								
	jistr	OPIG	INAL						
DHMH 17 Rev	1/200	001 OKIG							

Months

HUSPITAZ

71

7. Age (In yrs. last birthday)

10c. City, Town or Location

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

CorunalA

Days

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

Washington DC

Year

2007

Counsia

MD 21544

4c. County of Death

HOWARD

MAY

8. Date of Birth (Month, Day, Year) Jan 20, 1936

655 PM

	5 D-	Physic /Medi Examir	cal
4		uneral irector	
	ath with the Maryland	23a or 28a-f show ust be notified at	ral Director

JOAN

5. Social Security Number

579 48 0922

10a. State

Usual Residence of Decedent

MANYETTE

6. Sex

1 □ M 2 🛛 F

4a. Facility Name (If not institution, give street and number)

HOWALD COUNTY GENBRIAL

10b. County

Som

	iffe M	5	MD Howard	Columbi	La				1 1 les 2 1 1 1 0
	h the	ire	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Co	untry?
	th wit	Funeral Directo	8610 Snowden River Parkway	#310	2104	5	U	nited St	ates
	ems er mu	iner	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H	dispanic Origin? (Specify Yean, Mexican, Puerto Rican, e	s or No-	14. Race - Ame	
036	I within 72 hours after death with the Milene. Itene. r than "natural", or items 23a or 28a-f. the Medical Examiner must be notifie	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:		1 □ Yes 2 X No		,		hite
21215-0036	ר 72 ho "natur adical I	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. [Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of working	16b.	Kind of Business/	Industry
	d within 72 giene. ir than "na the Medic	Somp	Elementary/Secondary (0-12) College (1-4or 5	i+)	Homemake			Own Hom	e
yland	ild be filed lentat Hygi rked other ic event, t	To Be C	17. Father's Name (First, Middle, Last) Paul J. Manyotte John Paul Me	nyette		18. Mother's Name (First, Catherine G			
	shou and N s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street	and Number or Rural Route	Number, City	y or Town, State, Z	Zip Code)
Mar	alth alth 2		Joyce Fitz/Daughter	87	716 Wrights	Mill Road Ba	ltimor	e, MD 21	244
baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State		Disposition (Name of , crematory or other place			Location - City or	
	tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)			ery 5-5-2007		licott C	
ga	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	M01044		^{ss of Facility} Harry H Columbia Pike			
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do no	ot enter the mode of dyir	ng, such as cardiac or respir	atory arrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition A CV	TE RE	SPIRATING	P FAILURE		i	Onset and Death
de.	/Medical		resulting in death) Due to (or as	a consequence of	f):				
	Examiner		Sequentially list conditions b.	Sumon					2 WEGKS
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of	0:				
	ecute ind trans	Examiner	that initiated events C.						
Š,	oe ex cian a	Ē	Due to (or as	a consequence of	1):				
68/60 ,	ate b	dica	d						
	death certificate be executed a attending physician and d for use as the burial-transit	Physician/Medical	IF FEMALE:	of programmy					
ZOZ	ath o	ian		2 Fetal death		у		23d. Date of deli Month	ivery Day Year
	the a	sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of death	5 ☐ Other (specify) _				
7.	that the	F	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause giv	ren in Part I. 230	a. Did tobacco	use contribute to	the cause of death?
Records,	w requires that the d been signed by the should be detached	Completed by	FUNGEMIA	g	, g		1 ☐ Yes	- 1	obably 4 □Unknown
Ö	/ requ	etec		N. 300	,2				
ě	2 38 2	ld m	PERLIPHERAZ VASCOCAR	17150175	<u>G</u>		a. Was an autopsy performed?	24b. Were au prior to death?	topsy findings available completion of cause of
	n: The icate har, page		ISUTEMIC LEFT FOOT			1[Yes 2 X	Vo 1 ☐ Yes	2 (\$ X 0No
VII	Physician: this certificaral director, I	Be	25. Was case referred to medical examiner?		patient 3 DOA Oth	26. Place of Death (Checi		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
0	S D	ည	1 Yes 2 No Hospital: 1 Indip patie 27. Manner of Death 28a. Date of Inju			4 Housing Home St			cify)
SION	ding J. After funer	io	1 Natural 5 Pending (Month, Da	/ Year) Inj	jury Wor	yat k? Yes 2 □ No	scribe how inj	jury occurred	
2	death ctor: / the	icat	3 Suicide 6 Could not be 299 Bloom of init	urv - At home farr	m, street, factory, office		ation (Street	and Number or Ru	ıral Route Number,
<u> </u>	after Dire	Certification:	4 Homicide determined 266. Place of Injury	c. (Specify)	n, energy ractory, entre		or Town, Sta		nar riodte redniber,
_	spita ours neral fillec		29a. Certifier 1 Certifying Physician: To the best	of my knowledge.	death occurred at the til	me, date and place, and due	to the cause	(s) and manner as	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examiner: On the basis o and manner sta	f examination and	/or investigation, in my	opinion, death occurred at th	e time, date a	and place, and due	to the cause(s)
	Fo th within Fo th compl	Me	29b. Signature and title of certifier		29c. Licens	e number	29d. C	Date signed (Month	h, Day, Year)
	->-0		Denollymon	~~	D 36	9704		May 1	, 2507
•		- 1	,		1			1	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OM MOTHAYN O GIVAR

31. Date filed (Month, Day, Year)

ORIGINAL

10724 LITTLE PATUKENT PARICWAY

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 Elsie May 7:30 A. Martz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 200 June 29, 1919 Maryland Director 219-05-8068 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any linity or other traumatic event, the Medical Examiner must he profiled. 10c. City, Town or Location 10a. State 10b. County Od. Inside City Limits Frederick Frederick Maryland XXYes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21701 USA 14 James Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager **Retail** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Hoffman Nellie Naille ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Summers - sister 7910 Edgewood Farm Road, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 5-4-2007 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 samille 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as ass IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2∏ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate ha rector, page 2 autopsy perform death? 1 □ Yes 2 No 2140 1∐ Yes or Attending Physician: 25. Was case referred to-medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2/10/0 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၀ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are
To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

Fo the Hospital

State Registrar

one)

30. Name and a

31. Date filed (Month, Day,

29b. Signature and title of certifier

person no compose cause of death (Item 23a) (Type, Print)

32. Regist

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** A^M May 2007 4:08 Betty Lou Maggi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Under 1 Year ___ If Under 24 Hrs. Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) May 2, 1935 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕇 F Hours Months Days Min. Yrs. Washington, DC 579-48-7257 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 United States 13584 Deer Brook Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 9 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygik Important: If Item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Edwards James W. Dennis, Sr. 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13584 Deer Brook Court, Mt. Airy, MD 21771 Trish Milburn / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Stauffer Crematory 5/7/2007 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 8 East Ridgeville Blvd., Mt Airy, MD 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator Due to (or as a consequence of): Physician Days /Medical Examiner pneumoni Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Renal failure Atrial fibrillation 2 No 3 Probably 4 Onknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

he law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: ours after death.
neral Director: # within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

Certification: To Medical

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signa	ture and tit	itle of certifier	
		1 4	_
	'		
	// //		

14.8

29c. License number D62180

29d. Date signed (Month, Day, Year) May 1,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7th Street Frederick 400 W CS+ MD

State Registrar

32. Registres Signature 4 2007

and manner stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Nancy Albrecht Nichols 28 2007 \mathbf{P}^{M} 9:50 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2830 Mockingbird Court Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funera! 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🗹 F Months Hours 215-46-2691 64 30, **Director** Nov. 1942 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant of Health and marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel notified Annapolis Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 2830 Mockingbird Court 21401 U.S.A. Department of Health and Mental Hygiene. Important: if item 271s marked other than "natural; or items 23a any injury or other traumatic event, the Medical Examiner must bonee. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250No if Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 Widowed 45 Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Publications Director Education 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Albrecht, Sr. Ruth Baer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott C. Nichols/son 1119 Brassie Court Arnold, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Crematory 5/1/2007 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home Fodd 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCAR **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner i or Attending Physician: The law requires that the death certificate be executed attendeath.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be deached for use as the burial-transit in by the funeral director, Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2□No 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1-₩atural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar STATULIZY WATKING SPO 11. Date filed (Month, Day, Year) 32. Degistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 SPO DESTGITZ NO PANNAULIS 800 21401 2. Jegistra's Signature - Joseph

2007 | 608 |

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	State of Maryland / Department of Health and Mental Hygiene
	Certificate of Death

	Re	istrar Circh Middle Leet	7 Dodin	2. Date of Death	3. Time of Death
hysician/ اe ،Examine		Decedent's Name (First, Middle,Last) RANDALL ROBERT ORFF		Month Day May 10, 2007	Year 1710 hrs
	48	. Facility Name (if not institution, give street and number)	4b. City, Town, or Location o		c. County of Death Anne Arundel
		Chesapeake Bay Bridge	Annapolis If Under 1 Year If Under		NDD/YYYY) 9. Birthplace (State or
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours		Foreign .
Director	L	121W 2	'S.		
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hours after death with the Maryland "natural", or items 33a or 28a-f she Examiner must be notified at once		Widowed 4 Divorced If Yes, Give Yeer 1	Yes 2 X No specify:		Specify: White
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2121 ould be fill d Mental H s marked ic event,		Sa. Illioritatico realization	ing Address (Street and Nur Foxfield L	mber or Rural Route Number, ane Millin	City or Town, State, Zip Code) gton, MD. 21651
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more, MD 21 Pages 1 and 2 should tent of Health and Me ant: If item 27 is ma or other traumatic ev	ľ	crematon or		5/16/07	Crumpton, MD.
t. Pag	-			Al Home of	Stephen L Schaech
Baltimore, ME permit Pages 1 and 2 a Department of Health at Important: It item 27 injury or other traum:		M00510 1	Name and Address of Facilities at Lena Funer 18 West Cro	ss St. Gale	ena, MD. 21635
ysician	1	Pa Part I. Eilter the disease, or complications that caused the death. Do not enter failurer List only one cause on each line.	er the mode of dying, such as	cardiac or respiratory arrest,	shock, or heart Approximate Interval Between Onset and Death
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X 61 th cert ttendir truse a	icia	past 12 months? 4 Pregnant at time of death 5	Other (Specify)		
Records, P.O. Box 6 The law requires that the death cer icate has been signed by the attendi page 2 should be detached for use.		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in		cco use contribute to the cause of death?
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COF e law i te has t	Completed			performe 1 V Yes 2	ed? death? No 1 Yes 2 No
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Vital I hysician: this certiff	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other 4	ork2 28d Describe ho	w injury occurred
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Sior Attendr r death cctor: by the	cati	2 Accident Investigation 28e. Place of Injury - At home, farm,	street, factory, office building	, etc. 28f. Location (Str or Town, Sta	reet and Number or Rural Route Number, City
Divi	Certification	3 Suicide 6 Could not be determined (Specify) Major Road / Hight		Chesapeake Ba	ay Bridge, Annapolis, MD
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of (Check only)	occurred at the time, date and	place, and due to the cause((s) and manner as stated. nd place, and due to the cause(s)
To the within Fo the comple	Medical	and mainter stated	29c. License numb		29d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier Acade Mac	O.C.M.E.		May 11, 2007
		20. Name and address of person who completed cause of death (Item 23a)			
0		Tasha Greenberg MD. Assistant Medical Examiner	111 Penn Street, Baltir	more, MD 21201	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	arts		
Regist	trar	MAY 1 7 2007 Seeses 15.			

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Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)			· · · · ·		2 Date of Deat	h	3. Time of Death
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		 Facility Name (if not institution, give strength Chesapeake Bay Bridge 	reet and number)	"	Annapo		u i	Anne Arund	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1		_	th(MM/DD/YYYY) 9.	roian
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Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:		21. Signature of Funeral Service Licenset	M005	10 Ga	lame and A	Funeral	Home o	f Stephe	n L. Schaec . 21635
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exe	Medical		AMENDED						
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		etal death	3 Ectopic pre	gnancy	23d. Date of del Month	ivery Day Year
Box 687 e death certific the attending p	iciar	past 12 months?	4 Pregnant at time of de	a oth	ther (Speci		g.ru.roy		
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Division of Vital Records, tal or Attending Physician: The law require at safter death. Director: After this certificate has been sided in by the funeral director, page 2 should t	B B	25. Was case referred to medical			28	6.Place of Death (Che	eck only one)		
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risio	ficat	2 ✓ Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At h	nome, farm, stre	eet, factory,	office building, etc.			or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be datached for use as the burit	Certification:	4 Homicide determined	(Specify) Major Roa					Bay Bridge, Anna	
To the Hos within 24 hor To the Fun completely:		29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: C	n: To the best of my knowled on the basis of examination	ige, death occu and/or investiga	urred at the tation, in my	ime, date and place, opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as e and place, and due	s stated. to the cause(s)
To the within To the comp	Medical	29b. Signature and title of certifier	ind manner stated.			License number			(Month, Day, Year)
		Freshe St	eg mo			O.C.M.E.		May 11, 2007	7
		30. Name and address of person who co					MD 04004		
6		, actia crossing	ssistant Medical Exar			reet, Baltimore,	MD 21201		
	3 537	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ui o	00 D				

DUMH 17 Pey 1/200

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O 4 **Physician** 3 LI M 200 26 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 6. Sex 118 M 2□ F If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 7/26/1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Rhode Island 035-22-9184 Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City. Town or Location 10b. County 1 ☐ Yes 2 No MD Anne Arundel Odenton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number an "natural", or items 23a or Medical Examiner must be 21113 USA 528 Patricia Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No 1951If Yes. Give 1072 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes XX No Specify: White s, Give or Dates: 1972 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postmaster Postal Service the 12 should be filed w h and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Ernest Ostiguy Sr. Ethel Catlow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: if item 27 is r any injury or other traur Odenton, MD 21113 Marie Ostiguy Wife 528 Patricia Ct Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Crownsville 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 5/2/2007 MD 21. Signature of uneral Service Live 22. Name and Address of Facility Hardesty Funeral Home, P.A. MD 21401 12 Ridgely Ave. Annapolis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner C1) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examine 60 The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria 6 O N Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 ☐ Yes 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred accidental 27. Manner of Death 28c. Injury at Work? After 1 Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 02 20 2007 death. 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28 PAT NICIN CT, UNENDER W 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide HOME UNENTUN 24 hours a e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 1 2007

ICHAEL

32. Registrar's Signature

Susaw & Spark

Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Depa 1 - State Registrar Cert	rtment of Health and Me		giene 0 7	16084
	18		Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death
	Physicia /Medic		Helen Marcella O'Dea		Month May 0	7 2007 Year	7:59 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
,			49005 Harry James Rd.	Scotland Control of the Control		St. Mary'	
в	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 XF 80 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day	, Year) Cou	place (State or Foreign intry)
264	Director	Č.	578-40-0798 89 Yrs. 89		Dec. 7	191/ West	Virginia
	yland how		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
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	ith th	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	intry?
	s 23a	sral	49005 Harry James Rd.	20687		United Stat	
	item item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No	/as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F	lican, etc.)	Black, White	
39	urs af	by	If Yes, Give 1 3 ☑ Widowed 4 ☑ Divorced Year or Dates:	☐ Yes 2∏ No Specify:		Specify: Wh	ite
21215-0036	72 hou	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of workin	a	16b. Kind of Business/II	ndustry
2	ithin 7 ne. Me	nple	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)	9		
	led w lygier her th			tered Nurse 18. Mother's Name	(Eiret Middle	Health Ca	re
ano	ntal hed of ed of ed of	Be	17. Father's Name (First, Middle, Last)			waiden Surname)	
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I watural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To	James Fitzgerald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing	Marie He g Address (Street and Number or Rural		r. Citv or Town. State. Zi	ip Code)
Z S	nd 2 salth ar 27 is r trau			lly Drive Wheeling			
re,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me feel Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Dispos			20c. Location - City or T	
E	Page nent c int: If		1 🗆 Burial 2 💢 Cremation 3 🗀 Hemoval from State	d-Echols Cre May 8	2007	Charlotte	Hall. MD
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22.			d Funeral H	
	90 E # 9	113		955 Hollywood Road			
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Athenorytic	Lockovos	uler	11/13 eero	Year
	Examiner		Due to (or as a consequence of):				
	——₩	Jer	Sequentially list conditions, it of your against a immediate b. Due to or as a consequence of the conditions of the con			- 6	
	outed Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
Ö,	Attending Physician: The law requires that the death certificate be executed r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
8760,	ate b	dical	d				
Box 6	ding page as	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			004 5-1-44 5	
Bo	atten for u	by Physician/Med	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year
o.	the d	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
ري ص	s that	y P	Part II. Other significant conditions contributing to death but not resulting in the unconditions	derlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ğ	en sig	ed b	Part II. Other significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not resulting in the unit of the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to the significant conditions conditions conditions conditions conditions conditions conditions conditions conditi		1 □ Y	es 2□No 3□Pro	babiy 4⊟∪nknown
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ō	Phys this ral dir	<u>۲</u>	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA 4 Nursing Hom		ence 6 Other (Spec ow injury occurred	ify)
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Division or Vital	Atter r deal ector by the	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, stre building, etc. (Specify)	et, factory, office		treet and Number or Ru	ral Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.		29a. Certifier (Check only (Ch				
	the hin 24	Medical	one) and manner stated.	29c. License number	1,	29d Date signed (Month	Day Year)
	Sol Wit	-	29b. Signature and title of dertifler	34188	-	29d. Date signed (Month	, vay, 10ai)
	De		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)			
	13,		David M. Federle, M.D. 24035 Three No.		od Mar	rvland 206	36
	Sta	te	31. Date filed (Montal), 19 2007 32 Registrar's Signature		- 11d	200.	
	Registr	ar	Man to for				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1805 M ph 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Sa Wicomico Hos at the Lake pasta 168 Jalishurg If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) JUNE 7, 19 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Security Numbe **Funeral** Days 1 MM 2□ F Hours 76 035-20-1085 1930 RHODE ISLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1X Yes 2 No notified Director MARYLAND WORCESTER OCEAN PINES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 13 LOOKOUT POINT 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BUSINESS PRODUCTS 6 NUCLEAR PHYSICIST Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other transmission. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be O'BRIEN JOSEPH YVETTE BLANCHE LeCREREC 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY S. O'BRIEN/WIFE 13 LOOKOUT POINT, OCEAN PINES, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Dopation 5 Dother (Specify) CREMATORY OF DELMARVA 5/4/07 DELMAR, DELAWARE 21. Sign/ture 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications, or heart failure. List only one used the death. Do not enter the mode of dving, such as cardiac or respiratory arrest cations that Immediate Cause (Final Makastatia **Physician** disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner death certificate be executed and-tran-Due to (or as a consequence of) attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. I 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed has been s te 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 | No certificate 1☐ Yes 2 No 1 □ Yes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 ☐ Yes So No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Natural (Month, Day Year Injury 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death.

To the Funeral Director: completely filled in by the f To the Hospital

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

suall.

🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ted cause of death (Item 23a) (Type, Print) 30. Name and eddress of person who comple

29d. Date signed (Month, Day, Year)

Date filed (Month, Day, Year) 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 Month MAY 9 Physician HILDA М POOT.E 10:05A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 1 X F 217-10-0199 86 Jul 1, 1920 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dica Examiner must be notified at Maryland Frederick Walkersville 1 XYes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21793 56 West Frederick Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: **À** 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) ene. Elementary/Secondary (0-12) College (1-4or 5+) Assembly Manufacturing Company traumatic event, the other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fill the and Mental H Be Harry Clinton King Esther May Stottlemeyer Pages 1 and 2 should I nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health a Important; If item 27 i Mr. Earl M. King, Brother 8402 Cub Hunt Court, Walkersville, Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery May 14, 2007 Frederick, Maryland 4 ☐ Donaţion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Keeney & Bastord P.A. Funeral Home CODEMUN MOO706 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of: /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe No 3 Probably 4 Unknown 1 ☐ Yes pertension page 2 should Vascular Strike 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an TE bro autopsy 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

or Vital Records, Division Hospital or Attending 24 hours after death.
Funeral Director: / completely within 24

4

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, MAY 1

Thomas

7 2007

State Registrar

DHMH 17 Rev 1/2001

n who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29d. Date signed (Month, Day, Year)

Frederick no 21202

			1 State	partment of Health and Mertificate of Death	-				
		-1	1. Decedent's Name (First, Middle, Last)	Timoate of Boats	2. Date of Death	. No. 3. Time of Death	7		
No.	Physici /Medic		John Bernhardt Phillips		Month 4/28/				
	Examin	er	4a. Facility Name (If not institution, give street and number) 800 Besgate Rd.	4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arunde1			
4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	-	8. Date of Birth (Month, Pay, Y	9. Birthplace (State or Foreign Country)			
14	Director		214-01-4360 18JM 2LIF 96 Yrs.		4/1//191	1 Maryland	_		
	yland how at		10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits			
	e Ma 8a-f s	Director	MD Anne Arundel Annapol	_		1 □Yes 2 □No			
	3a or 2 st be no		10e. Street and Number 800 Besgate RD	10f. Zip Code 21401	10g	. Citizen of Wh <i>a</i> t Country? USA			
336	be filed within 72 hours after death with the Maryland tital Hyglene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Nus Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
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d 2	filed withir Hygiene. other than ent, the Me		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		_		
/lan	should be I ind Mental I s marked or umatic eve	To Be	Charles Phillips Sr.	Lillian	Bernhard	lt			
Maryland	and and s m	. 8	1	iling Address (Street and Number or Rur Willard St. Wilm	al Route Number, C ington De				
d)	Health tem 27 I	1	, , , , , , , , , , , , , , , , , , , ,			oc. Location - City or Town, State	_		
E O	Pages nent of int: If I	1	NEXBURAL 2 Cremation 3 Removal from State	t Cemetery 5/1/	2007 An	napolis, MD			
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Lice see	22. Name and Address of Facility Har 2. Ridgely Ave. Ann					
y		1	23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	t, Approximate Interval Between Onset and Death					
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cancer		6 month	2		
	/Medical Examiner		Due to (or as a consequence ot);						
8		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				_		
	recuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
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Θ	tificate ig phys as the	ledic	d.						
Вох	leath certific attending p I for use as	an/N		B_Ectopic pregnancy		23d. Date of delivery Month Day Year			
0.	The law requires that the death certifice has been signed by the attending to have a should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	☐ Other (specify)		mond. Day			
Δ.	ires that the de signed by the a be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?			
ord	w require been sig should b	ted t			1 ☐ Yes	2 No 3 Probably 4 Unknown	_		
Records,	The law sate has b page 2 st	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?			
Vital			25. Was case referred to medical	26 Place of Deat		No 1 □Yes 2 □ No	_		
Ž	S (S :=	To Be	examiner? 1 Yes 2	Other		ce 6 ☐Other (Specify)			
n or	ng Ter		27. Manner of Death 1 ☐ Hatural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how		Т		
Division	Attenr death	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office		et and Number or Rural Route Number,			
Ö	ital or irs afte ral Dir	Cert			City or Town,				
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Pertifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.						
	To th within To the compl	Me	29b. Signature and title of dertifier	29c. License number	29d	I. Date signed (Month, Day, Year)			
		5	I Tiseth Frend M-D	01.1(9)		1/30/017	_		
	Br	J .		ense they An	napolis	wd. 21401			
	Sta Registi		31. Date filed (Morth), Day, Year) MAY 0 1 2007	Secret a	V	,			

			State of Maryland / Depa		nental Hyg	giene
				rtificate of Death		Reg. No. 007 1000
15	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year
No.	/Medic		Mary Ruth Pendergrast 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 8	, 2007 11:15 A ^M
	Examir	ier	Bayside Care Center	Lexington Park		St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	h 9. Birthplace (State or Foreign
k	Director		235-20-3027 1 M 2 TF 87 Yrs.	Months Days Hours Will.	04/09/	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryl -f sho jied a	tor	Maryland St. Mary's Lexington	n Park		1 □Yes 2 No
	h the or 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	23a c	ral	21412 Great Mills Road	20653		United States
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 MNever Married 2 Married 1 Mes, Give 1 Mount 1 Mes, Give 1 Mes, Give 2 Mes 1 Mes 2 Mes	1 ☐ Yes 2 ▼ No Specify:		Specify: White
215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	pel		dent's Usual Occupation		16b. Kind of Business/Industry
215	thin 7: e. an "n Medl	Jple	(Specify only highest grade completed) (Give life. Sementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ring	
7	ed wil ygien er th t, the	Completed	Ž Sec	retary		Veterans Administration
Maryland	S should be filed and Mental Hygin is marked other aumatic event, the	Be	17. Father's Name (First, Middle, Last)			Maiden Surname)
ž	should be fand Mental Is marked of	은	Paul Charlie Pendergrast 19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	Nelle 0.		
<u>⊠</u>	25 m					Hall, Maryland 20622
Ē,	ges 1 and 2 It of Health If item 27 or other tr		20a. Method of Disposition 20b. Place of Dispo		Date	20c. Location - City or Town, State
altimore,	Page nent c int; if	1	T Durial 2 Defination 3 Demoval from State	1	1/2007	Helen, Maryland
alt	permit. Pages 'Department of H Important: If ite any Injury or ot		21. Signature Funeral S., ce cense.			-Echols F.H., P.A.
<u> </u>	20 E # 9	1_1\				arlotte Hall, MD 20622
1			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory an	rest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ralogy Fail	WVE	= 2 days
	Examiner		Due to (or as a conjequency of):	a store ha	SF	luna sinta
4	art payet	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	con eyeu	2/ 100	un or or or
	ocute o	Examiner	that initiated events c.	comyo sal	ny	yr.
760,	ate be executed hysician and the burial-transit		Due to (or as a consequence of).	2 1. A Tayli	Tha	l e M
687	icate physi s the I	dical	d. Oloyla	M/MONON	100	y y
Box (The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
m	death e atte	icia	in the past 12 months? 1 Ves 2 10 No. 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	at the by th	hys	9 ☐ Unknown			
	res that the de signed by the a be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to the cause of death?
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Rec	helaw hasl ge 2 s	mpl	Schrophrema		24a. Was a autop: perfor	sy prior to completion of cause of
Vital			25. Was case referred to medical	00 Plans of Passi	1□ Yes	2 to large 2 No
	S S E	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death		ence 6 □Other (Specify)
Division or	ding Phys h. After this funeral dir	-	27. Manner of Death 28a. Date of Injury 28b. Time of Death 28b. Time o			ow injury occurred
	Attending it death. ector: After by the funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Š	or Attencather death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (S City or Tow	itreet and Number or Rural Route Number, rn, State)
	pltal ours a leral [29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	h occurred at the time, date and place	and due to the	course(c) and manner as stated
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time,	date and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
	T 10	1	benset laston W) D06419	1	5-9-07
1	My		30. Name and ad In ss of person who completed ause of death (ftem 23a) (Type,			/
	Sta	to	James Patrick Jarboe, M.D. 24035 T	Chree Notch Road,	Hollywoo	od, MD 20636
	Registr		MAY 1 0- Lyon	And		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** 2, 12:45 p M May Margaret Α. Reyda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Montgomery Hospice-Casey House Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Min. March 28, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months 1 □ M 2 1 □ F Yrs 211-30-5380 68 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Indian River Vero Beach Florida 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32967 IISA 1640 Victoria Circle Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify SpecifyWhite ş 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "
Iry or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Kingora Margaret Ann Holonich ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1640 Victoria Circle, Vero Beach, FL 32967 Steve J. Reyda/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State May 4, 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 7 500 University Blvd, W., Silver MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Multiple Sclerosis
Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed: 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Hospice this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ₩ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) by 4 | Homicide

or Vital Records, P.O. Box 68760, Hospital or Attending after death n 24 hours after le Funeral Dire letely filled in b completely To the I

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

29a. Certifier

m Dellomo DO

140058032

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Williams, D.O. 6001 Muncaster Mill Road, Rockville, MD 20855

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 03 200



The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: 24 hours a within 24 ho

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Certification: To

Medical

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				performed? 1□ Yes 2XNo	death? 1 ☐ Yes 2 ☐ No						
25. Was case referred to medic	eal	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2[XNo	Hospital: 1 ☐ Inpatient	2 ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5 ☐ Residence 6	Assisted XiOther (Specify)Living						
Z Accident	tigation	ear) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred						
3 Suicide 6 Coul 4 Homicide detei	mined 28e. Place of injury - building, etc. (S	At home, farm, street, fac Specify)	ctory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,						
	ring Physician: To the best of m ai Examiner: On the basis of exa and manner stated	amination and/or investiga									

29b. Signature and title of certifier

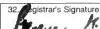
29c. License number 29d. Date signed (Month, Day, Year) D09834 May 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum, MD, 3720 Farragut Ave., Kensington, MD 20895

State Registrar 31. Date filed (Month, Day, Year)

03 MAY



State Registrar

Anurita Mendhiratta, M.D.

03

2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

death with the Maryland

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

egistrar's Signature

2401 Research Blvd. #330 Rockville, Md. 20850

07-03162
Cheryl Lynne Rowland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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, ,	1- For State Certificate of Death Reg. No.								1					
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)									Date of Deati Month		ear	3. Time of D 2110 hr	
edical Examine		CHERYL LYNNE ROWL								April 24, 20	007			5
	48	. Facility Name (if not institution, give	street and number)		4t	. City, Town	or Lo	cation of	Death		4c. Count	•	tn	
		10 Village Street #98				Easton		_			Talbot			
Funeral	5.	Social Security Number 6. Se	x 7. Age (In	yrs.last bir	thday)	If Under 1	$\overline{}$	If Under	_	8. Date of Birt	h(MM/DD/YY	Fore		1
Director		10.50.0016	M 2 X F	47	Yrs.	Months [Days	Hours	Min.	FERRUAR	23,19	60 C	Country) NEW	JERSEY
		49-50-8046 1 1 sual Residence of Decedent	- 22	47		L								01111111
any	10	na State 10b. County		c. City, Town		n							10d. Inside	
*	120	EW JERSEY UNION TALBOT	12.	WESTFTE ASTON	מדה								1 Yes	2 A No
faryland 28a-f show at once.		Do Street and Number		IDIOI		10f. Zip C∞				1	0g. Citizen of	What Co	ountry?	
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th the notif	1	O VILLAGE STREET 1. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was	Decedent of	f Hispa	anic Origi	n? (Spe	cify Yes or No	- 14. Ra	ce - Am	erican Indian, E	Black,
death with t	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Never Married 2 Married	Armed Forces?		If Ye	es, specify Q	ıban, l	Mexican,	Puerto R	ican, etc.)	W	hite, etc.		
or dez			1 Yes 2 X	No	1	Yes 2 X	No	specify:			Specit	y: WH	ITE	n 4
s afte	≩⊢	15. Decedent's Education (Specify or	or Dates:	ted) 16a	. Decedent	's Usual Occ	upatio	n (Give k	ind of wo	rk done	16b. Kind of	Busines	ss/Industry	
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36 lin 72 than dical	릷	12		(ONT.T N	E MANA	GER	}			INTER			
5-0036 lled within 7 Hygiene. to other than	5 -	7. Father's Name (First, Middle, Last)				18	8.Mother's	s Name (First, Middle,	Maiden Surna	me)		
215. be filed ntal Hy rked of		ELLIS ROWLAND					-	SUZA	NNE	WALLBA	NK			
21215-003 unid be filed withi Mental Hygiene, marked other ti	0 1	9a. Informant's Name/Relationship (Type, Print)										ate, Zip Code)	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland than and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f 5th annuatic event, the Medical Examiner must be notified at once annual control of the Commission of the English of the Englis	- 1	TICHAEL ROWLAND/B			248 N	ICHOLS	MA	NOR	DRIV	E, STE	VENSVI	LLE,	MD 216	<u> </u>
alt malt		20a. Method of Disposition		20b. Place	e of Dispos	ition (Name o	of cem	etery,		Date RIL 26	20c. Locati	on - City	or Town, State	•
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	+,	23a. Part I. Enter the disease, or com	olications that caused th	e death. Do	not enter t	he mode of d	ying,	such as c	ardiac or	respiratory ar	rest, shock, o	r heart	Approxim	nate Interval
Physician 'Modical		failure. List only one cause on e	ach line.											Death
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760, icate be physici the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth			etal death	3	Ectopi	ic pregna	ncy	Mon		Day	Year
68 certif nding se as	sician	past 12 months?	4 Pregnant at ti	me of death		ther (Specif								
Box 687 e death certific the attending	Ĭğ	1 Yes 2 No 9 V Unknow	vn g Unknown											5 1 11 0
⊞	F	Part II. Other significant conditions	s contributing to death	but not resu	Iting in the	underlying c	ause (given in P	art I.				te to the cause	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the its after death. Tal Director: After this certificate has been signed by the funeral director, page 2 should be detach.	ğ									1 Y			Probably 4	
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Hos 24 h Fur		Oriodit diny	sician: To the best of my	knowledge,	, death occ	urred at the t	ime, d	late and p	place, and	d due to the ca at the time, da	ause(s) and mate and place.	anner as and due	s stated. e to the cause(s	s)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical	one) 2 Medical Exami	ner:On the basis of exan and manner stated.	mation and	, or investig							and place, and due to the cause(o)		
ESES	Z	29b. Signature and title of certifier			29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 25, 2007					,				
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4		30. Name and address of person w	/		3a)		-			D. 0.100.				
12/		Tasha Greenberg MD.	Assistant Medica			1 Penn Si	treet	, Baltim	ore, M	21201 ט				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** May 2, 12:50 a^M 2007 Elizabeth Jane Ridge11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Great Mills
If Under 1 Year | If Under 24 Hrs. St. Mary's 21724 Garfield Street 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours 1 ☐ M 2 🛛 F 84 338-18-3841 Director 01/14/1923 Michigan Usual Residence of Decedent 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits Hygiene. kther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director St. Mary's Maryland Maryland Scotland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "--- any injury or other traumant." 14909 Ridgell Way 20658 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White ş 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Statistician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William T. Viant Lydia Senical 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Ridgell/Son 12870 Lake View Drive, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's Cem. 05/07/2007 | Ridge, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service License 22955 Hollywood Road, Leonardtown, MD 20650 Kyle S. Simons M01206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as nordiac or respiratory arrest, shock, or heart failure. List only one cause on each live Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: esn. 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 2/2 No Completed page 2 should Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 5 ☐ Residence 6 Other (Specify) Home Other: 1 ☐ Yes 2 No 3□ DOA ို 2 ER/Outpatient 4 Nursing Home 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1/A Natural after death.

I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 24035 Three Notch Road, Hollywood, Maryland James P. Jarboe, M.D 32. Registrar's Signatu 31. Date filed (Month, Year) State 2007 MAY 0 7 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Day MAY 2ď87 **Physician JEAN** RAGEN 12:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Ye Dec. 31, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Funeral Year 1 □ M 2 🗓 F 76 Scotland 300-26-9596 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ns 23a or 28a-f show must be notified at 1 √ Yes 2 No Director Maryland Carroll Mount Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 626 Calliope Way 21771 U.S.A. items 23a Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status "natural", or item edical Examiner n Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fil h and Mental H 7 is marked oth Be Susan Leishman ၉ Benjamin Carson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai Karen S. Screen - Daughter 12343 Sherwood Forest Drive, Mount Airy, Maryland Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Ottawa Hills Mem. Pk. 5/12/07 Toledo, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F neral Service Licensee Molesworth-Williams P.A., Funeral Home Hovers 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC Physician SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ABDOMEN ACUTE Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the bunal-transit ACIDUSIS Due to (or as a consequence of): Box 68760. death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ HTN - HYPERTENSIUN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 1. Natural 5 ☐ Pending investigation s after deameral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063498 5-2-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 WADHWA LAKHVINDER 400 West 7th Street, Frederick, Maryland 32. Register's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of Marylan		artment of I		Mental Hy	rgiene 0 0 7	16095
Physic /Med		1. Decedent's Name (First, Middle, Las	eynolds				2. Date of De Month	Day Year 30 2007	3. Time of Death 7:00 PM
Exami Funeral	ner	4a. Facility Name (If not institution, give 573 Village 5. Social Security Number 6. Social Secu	Court 7. Age (In yrs.		4b. City, Town, of Salvs If Under 1 Year Months Days		Irs. 8. Date of Bi	4c. County of Dea	
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ath with the Marylar 23e or 28e-f show	ector	Maryland Wicom 10e. Street and Number		lisbu				10g. Citizen of What C	1 Yes 2 □ No
ath with 8 23a or	Funeral Director	573 Village			218			United Sta	tes of america
i. K. 13-0030 within 72 hours atter death with the Maryland ene. then "natural", or Iteme 23a or 28a-1 show the Maryland Exercities at the Mailcal Exercities; and the mailcal exercities at the mailcal exercities at the mailcal exercities.	b	11. Marital Status 1 □ Never Married 25 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	14. Race - Am Black, Wh Specify: B	encan Indian, te, etc.
If yiell (Z Z D-0050 should be filed within 72 hours after de Id Mental Hygiene marked other then "natural", or flem matte event. Its Medical Extrainer?	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of v	working	16b. Kind of Business	
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Mc d 2 : th ar T is treu		20a. Method of Disposition	Reynolds/	1137	ng Address (Street Control Sition (Name of matory of other pla	Bonda	- 1 -	Per, City or Town, State, Princess A 20c. Location - City o	nne, MO
Dallinore, permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other page.		Durial 2 Cremation 3 Capacity Donation 5 Other Specify 21. Signature of Fureral Service Licen) State	emois	Courcest Name and Addre	ns Ma	y 5, 2007 Anthony	- e ward 4	MD Home
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/Medical Examiner	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence to for a consequence to	uence of):	etes				2110
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To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has a completely filled in by the funeral director, page 2.	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1	ry at rk?]Yes 2 □ No		how injury occurred	
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Alies completely filled in by the fune		4 Homicide determined	building, etc. (Specif	Y)			City or To	(Street and Number or R wn, State)	
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4 8		30. Name and address of person who of	completed cause of death (Item	23a) (Type,	Print) 1/	- 55	Salus	5/3/2007 7 MD 210	3~)
St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 0 4 2	32. Pagistrar's Signa		and a			1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Death		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Vargare /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DRO aRP 8. Date of Birth (Month, Day, Y April 8 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□M 21 F 9 1912 Germány Director Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 23 is marked other tran "natural", or items 23a or 28a-f show any injuy or other tranmatic event, the Medical Examiner must he now force. 10d Inside City Limits 10c. City, Town or Location 10a. State 1X1Yes 2∏No Baltimore Baltimore City Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 5407 Knell Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 White Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Draperies & Upholstery Elementary/Secondary (0-12) Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Unknown Ernest R Walther 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Lyndale Avenue Baltimore, Maryland 21236 19a. Informant's Name/Relationship (Type. Print) 126 Lyndale Avenue Hribar Debra L. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial park May 14 2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home Inc 21. fignature of Funeral Service Live see 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Demonte /Medical Due to (or as a consequence of): Examiner Due to (or as a) nsequence of): 23 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Georphia burial-tran and Due to (or as a consequence of) Box 68760, been signed by the aftending physician should be detached for use as the buria Hyperter Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s 2 No 1 certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 ER/Outpatient 1 🗌 Yes 2[JHO 1 🔲 Inpatient ို this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Medical Certification: After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) MAY 1 7 2007

MAZHMI

N. ENTAN ST Sonte 308 BALTIMORE MD 21201 821 . Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Medical

Funeral

Director

Physician /Medical Examiner

death certificate be executed as

Box 68760

P.O.

Records, Division or Vital To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

> State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 30 :20 A M 2007 Lisa Μ. Saia 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea BALTIMORE WASHINGTON MEDICAL CENTER ARUNDEL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Days Hours 1 M 2 SF 213-84-9908 July 24, 1963 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 609 Tanyard Cove Road 21061 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced 1982-85 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private First Class Military 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Martin Saia Bettynelle Elaine White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candace M. Ricketts/ Sister 13204 Dumbarton Drive, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2, May Metropolitan Crematory 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 5 500 University Rlvd, W. Silver Spring, MD 20901

enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death CHRY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as DAGULOPATH Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2**□ N**0 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a, Certifier (Check only one) 29b. Signature and title of contifier

29c. License number 29d. Date signed (Month, Day, Year)

MEDICA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL

DRIVE, GLEN BURNIE, MD

BERHAVE, 15:00 31. Date filed (Month, Day, Year) 03 2007

BATTIMORE ASHINGTON

DHMH 17 Rev 1/2001

+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Day 200 7 ear 2, 5:55 am Smith V . Florence 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Nursing and Rehab. Center Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | April | 14, 1927 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Loudoun Co., VA 80 231-56-2167 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Germantown MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20874 17010 Germantown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2**X** If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Provider Nursing Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melinda Trammell Grooms James A. Grooms, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew W. Johnson, Jr. / Son 17010 Germantown Road, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State Mt. Olive Bapt Church Cem 5-8-2007 Lincoln, Virginia 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Lyles Funeral Service P.O. Box 397, Purcellville, Virginia 20134 w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emontia ears Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1000 VISCASC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner Examine executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u>

after

72 hours

filed within Hygiene.

and 2 should be file thealth and Mental H

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau

altimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

death certificate be

burial-transit and attending physician Physician/Medical the as use ę s been signed by the should be detached þ Completed page 2 certificate Be

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Certification:

Medical

After this funeral

filled in by the

e Hospital or Attending 24 hours after death. Funeral Director: After

To the I within 24 IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner? 2 No 1 Yes

27. Manger of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2007

28d. Describe how injury occurred

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

1.20148

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave. Gaithersburg, Maryland

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

2007 03



			1 - For State Registrar	Stat	e of Mar	yland .				lealth a	and M	lental Hy	Reg. No	007	161	00
·	Physici	an	Decedent's Name (First, Middle	a, Last)								2. Date of Do Month	eath Day	Yeer	3. Time of	
	/Medic		DONALD RUSSELL									MAY	2	2007		5 AM
n de	Examin	er	4a. Facility Name (If not institution		nd number)					r Location o	of Death			ounty of Dea	ith	
			TALBOT HOSPICE 5. Social Security Number	HOUSE 6. Sex	7 Age	(In yrs. last	birthday)	EAS'	r 1 Year	If Under :	24 Hrs.	8. Date of Bi	rth	JBOT 9 Bir	rthplace (State of	or Foreign
Н	Funeral Director		579-28-7279	1(X M 2□	TE .	78	Yrs.	Months		Hours	Min.	JULY 9	ay, Year)	C	YLAND	o, 1 0, 0, g, 1
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and	mital l) Be										ELIZABI				
Maryland	should be and Menta s marked umatic ev	ဥ	JAMES RUSSELL S 19a. Informant's Name/Relations		t)		19b. Mailin	g Addres	s (Street			a/ Route Numb			Zip Code)	
Š	27 in		ALMA SAMPSON/WI	FE		4	4258	CHAR	LES L	ANE.	PRES	STON, M	ARYLAN	D 216	55	
e .	of Heal		20a. Method of Disposition			20b. Place	e of Dispo	sition (Na	me of	I	1	Date 7,			r Town, State	
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alt	sparting sparting y inj		21. Signature of Funeral Service	Licensee			22 FF	Name a	nd Addres	ss of Facilit	RETN				AL HOME,	
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and the same of	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Hau	te n	nye	101	1	Ruk	en.	110				25
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Вох 6	attending pr	Physician/Med	IF FEMALE:	220 If yo	s, outcome of	neaganan										
Bo	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	101	Live birth 2 Pregnant at tir	☐ Fetal de	ath 3	Ectopic	pregnancy	,			23	d. Date of de Month	•	Year
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Records,	n sign	d by	Diabetes, Lo	oft he	art f	ailur	re,	HUDE	rter	15101	7.	10	Yes 2X	No 3 □ P	robably 4 🗆	Unknown
၀	s been sign	Completed	COPD asher	stosis				//			,	24a. Wa		24b. Were a	utopsy findings	available
<u>۾</u> ۾	nystcten: The law his certificete has t I director, page 2 s	E O							-			auto perf 1 ☐ Yes	ormed? 2 No	prior to death? 1 \(\subseteq Yes		cause of
Ita	rtifice tor, p	0	25. Was case referred to medical							26. Place	of Deatl	h (Check only			2 2 3 110	
>	Thysic this ce al direc	To B	examiner? 1 ☐ Yes 2 No	Hospital:	1 Inpatient	2□ER	/Outpatien	t 3□ C	OA Oth	er: 4 Nu	rsing Ho	me 5□Res	idence 6 [Other (Spe	ecify)	
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sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	gation not be				М		Yes 2□I						
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	yithing nospital or Attending the within a within a hours effect death. To the Funerel Director. After the completely filled in by the funeral	Me	29b. Signature and title of certifie		/	1		25	c. License	e number			29d. Date	signed (Mon	th, Day, Year)	
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	YAS		30. Name and address of person	who completed	d cause of dea	th (Item 23	За) (Туре,	Print)	n	11	7	1601		1		
\	11		3.38 Cyn M	100d	Dry #	2, 1	ras	JON	, 14		di					
	Sta Registr		31. Date filed (Mosth Av., Val.	2007	SZ Jagistrar	s Signatu	R	BULL				1601				

	_	Stete Registrar	Certificate	of Health and N of Death	Re	g. No.	10101
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Ronald Earl	Shipp		2. Date of Death Month May 3,	Day Year 2007	3. Time of Death 2:20 A M
Examin Funeral Director		4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home 5. Social Security Number 216-50-7161 6. Sex 1 Sex 1 Sex 2 F 59	Chast birthday) If Under 1	wn, or Location of Death arlotte Hall Year If Under 24 Hrs. Days Hours Min.		Year) 9. Bi	Mary's thplace (State or Foreign ountry) ryland
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Itam 27 is marked other than "naturel", or Itams 23s or 28s-f show other traumatic avant, the Medical Examinational particular at	To Be Completed by Funeral Director		13. Was Deceder If Yes, specify 1 Yes 25 16a. Decedent's Usual (Give kind of work life. DO NOT use	ode 0622 t of Hispanic Origin? (Sp. Cuban, Mexican, Puerto t No Specify: occupation fone during most of work retired) Plant Techn	recify Yes or No-Rican, etc.)	6b. Kind of Business Departmental daiden Sumame)	erican Indian, ite, etc. White
permit. Pages 1 end 2 should be Department of Health and Mental Important: If itam 27 is marked eny Injury or other treumatic av QDCB.	. 0	1 Burial 2 XCremation 3 Removal from State	9010 Coppe ace of Disposition (Name Imetery, crematory or othe Insfield—Echo 22. Name and Brins	r place)	Washing Ty S Funeral	gton, MD 2 Oc. Location · City of Charlotte L Home, P.	Town, State Hall, MD
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ires that the death certifi signed by the attending d be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contributing to death but not resu	death 3 □ Ectopic preg ath 5 □ Other (spec	fy)			Day Year o the cause of death?
itsi or Attending Physicien: The law requires that the rs efter death. In Director: After this certificate hes been signed by the lad in by the funeral director, page 2 should be detached in by the funeral director.	Certification: To Be Completed by	25. Was case referred to medical examiner? 1	me, farm, street, factory, o	Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No	24a. Was an autopsy perform 1 Yes 2 h Check only one ome 5 Resider 28d. Describe how 28f. Location (Str. City or Town,	24b. Were a prior to death? 1 Yes 1 Yes 1 Yes 24b. Were a prior to death? 1 Yes 24b. Were a prior to death? 24b. Were a prior to death? 24b. Were a prior to death?	utopsy findings available completion of cause of s 2 - No secify)
To the Hospital or & within 24 hours effer To the Funeral Dire completely filled in b.	Medical	29a. Certifier (Check with one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item	on and/or investigation, in	my opinion, death occur icense number 245092	red at the time, da	te and place, and du d. Date signed (Mon	e to the cause(s)

		-	For Stete Registrar	State of Maryla		artment of H			ene g. No.	7 15102
	Physici		1. Decedent's Name (First, Middle, Last) Cecelia Elizabeth					2. Date of Death Month 7, 2		Year 3. Time of Death 5:25 A M
	/Medic Examin		4a. Facility Name (If not institution, give s Charles County Nur			4b. City, Town, or LaPlata	Location of Death		4c. County of Charl	
	Funeral Director		5. Social Security Number 6. Sex 189-22-5074	IM SETE	rs. last birthday) 30 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Sept. 23	Year)	9. Birthplace (State or Foreign Country) Pennsylvania
	Maryland f ahow	tor	Usual Residence of Decedent		Charlo	tte Hall				10d. Inside City Limits 1 ☐ Yes 2X No
	or 28a	Director	10e. Street and Number	3	Onario	10f. Zip Code		10	g. Citizen of W	hat Country?
	ath wil		13620 Padgett Cou			206			USA	
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Department of Heath and Mental Hyglene Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show say figury or other traumatic avent, the Medical Exerciting mant be maillised at ODGe.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	'	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐xNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	Becity Yes of No- Brican, etc.)		- American Indian, (, White, etc. White
21215-0036	in 72 hou	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	of work done during most of working			siness/Industry
212	giene.	L Com	Elementary/Secondary (0-12)	College (1-4or 5+)	S	ales Cler			Reta	
Maryland	uld be file Aental Hy rked oth tic avent	To Be (17. Father's Name (First, Middle, Last) Stanley Ko	sarek			18. Mother's Nam	ne (First, Middle, Mi	aiden Sumame locota	a)
Mary	od 2 shoulth and N		19a. Informant's Name/Relationship (Ty Susan Earle/Daugh					ral Route Number, Charlotte		State, Zip Code) MD 20622
J.	of Hea		20a. Method of Disposition	1	b. Place of Dispo cemetery, crei	osition (Name of matory or other place	e)	Date 2	0c. Location - (City or Town, State
Baltimore,	Page Iment tant: If		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	M		Veterans		1/2007	Che1ter	nham, Maryland
Ball	Departi Depart Import any in		21. Signature of Funeral Service License	M0064	41	30195 Thr	d-Echols ee Notch		narllot	e Hall, MD 20622
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the cause on each line.	1 =	ter the mode of dyin HALVE		or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a con						
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a con	sequanca off.					
8760,	cate be executed physicien and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
P.O. Box 68	death certifi e attending id for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	e of delivery hth Day Year
	8 & e	d by Ph	Part II. Other significant conditions col	ntributing to death but not	resulting in the u	ınderlying cause gıv	en in Part I.	23e. Did toba	1	ibute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	> 0 0	Completed						24a. Was an autopsy perform	ed? d	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	20 1	ath (Check only one		
of	Phys r this eral dir	. To	1 ☐ Yes 2 No	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time o	nt 3L DOA	4 Nursing H	fome 5 Resider 28d. Describe how		
ision	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filted in by the funeral director, page 2	Certification;	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury -	At home, farm, st	M 1 🗆	k? Yes 2 □ No	28f. Location (Str.	eet and Numbe	er or Rural Route Number,
Ö	Hospital or A 24 hours after Funeral Dira stely filled in b		4 nomicide	building, etc. (Sp		th occurred at the time	ne date and place	City or Town,		nnar as stated
	To the Hose within 24 ho To the Func completely f	Medicai	(Check only 2 Medical Exami	iner: On the basis of exar and manner stated.	nination and/or in	ivestigation, in my o	pinion, death occu	irred at the time, da	te and place, a	and due to the cause(s)
)	To Your	~	29b. Signature and title of certifier	MD		29c. Licens	05790	79	5/9	1107 aldorf, MD 2060
_			1 1	WALA, MD	1163	Print) 7 Terra	ce Drir	re, Ste	103 6	aldorf, MD 2060
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 0 2007	32. Registrar's S	ignature					

ORIGINAL

Amended Item 22 per F.D. 05/02/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Vea **Physician** 0830 AM Annetta 2007 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖵 F Director Aug 20 1945 PA 212-44-2145 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Exaπiner must be notifled at Yes 2 No Director MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21787 27 Hayride Lane Funeral death 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced White 'natural' Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Security Elementary/Secondary (0-12) College (1-4or 5+) Agency 12 Computer Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary DiOrazio John Rieccuto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trace Wolfgang Spreen/husband Hayride Lane Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Evergreen Mem Gardens Finksburg, MD Pritts Funeral Home and Chaspel, 21. Signature of Funeral Service Licensee P.A. 412 Washington Rd Westminster, 21157 MD23a. P. dd. Enter the disease, or complications line coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Hemorrhage Enours /Medical Due to (or as a consequence Examiner huticoaculation Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Pulmonary burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? for Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an erform Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Impatient 2 ER/Outpatient 3 DOA Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MST RES-OOC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 The Johns Hopkins Hospital 600 North Wolfe Street maryland Amy DeZoin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 2 2007

DHMH 17 Rev 1/200

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2, 2007 P^{M} May 6:30 ALICE LILLYAN STEINER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Golden Living Center Frederick Frederick 8. Date of Birth (Month, Day, Year) July 15, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1915 Wisconsin 399-14-1522 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 TYes 2 No Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30 North Place 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leslie Byron Porter Rhoda Emily Davidson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chuck Harp / Nephew 4131 Springview Drive, Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake Lawn-Metairie Cem. 5/10/07 New Orleans, Louisiana 21. Signature of Funeral Service License ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. one cause on each line CANCER Immediate Cause (Final disease or condition resulting in death) OLON Due to (or as a consequence of): IHRIVE FAILURE Sequentially list conditions, Due to for as a consequence of).

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any injury or other traum once.

Physician

/Medical

Examiner

Director

2

Completed

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Madical Exeminer must be notified at

2 should be filed within 72 hours after death is and Mental Hyglene. Is merked other than "natural", or Items 23s

Baltimore, Maryland 21215-0036

Maryland

the

Medical Certification: To Be Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit been signed by the should be detached certificate has L irector, page 2 s After this certification funeral director. To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Division of Vital Records, P.O. Box 68760,

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consect	juence of);			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 □Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc 1 ☐ Yes	24b. Were autopsy findings available
				autopsy performed 1 Yes 2	prior to completion of cause of death?
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Junursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac	tory, office	28f. Location (Stree City or Town, Si	t and Number or Rural Route Number, late)
	ysician: To the best of my kn iner: On the basis of examin and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and little of certifier			29c. License number	29d.	Date signed (Month, Day, Year)

5-04

FREDERICK

7005

State Registrar

31. Date filed (Month, Day, Year)

A. KAZMI, MD

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jun)



		•	For State Registrar	State o	of Maryland		artment of F tificate of		nd Mental I	Hygiene Reg. No	211117	16105	
			1. Decedent's Name (First, Middle	, Last)					2. Date of	Death Da	v Year	3. Time of Death	
	Physicia /Medic		Robert	Joseph S	cully					1 30,	•	9:07P M	
	Examin	-	4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	or Location of	Death	40	. County of Dea	ith	
			Grace House Ass	sisted Li	ving		Silver				Montgomery		
	Funeral		5. Social Security Number	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. la		If Under 1 Year Months Days			Birth , Day, Year)	9. Bir	thplace (State or Foreign ountry)	
	Director	ļ	217-03-8001	1121M 201F	87	Yrs.			Feb.	5, 19)20 Ma	ryland	
	Du 🖈	}	Usual Residence of Decedent 10a, State 10b, County		10c, City	Town or Lo	cation					10d. Inside City Limits	
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	7 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Directo	Maryland Monts 10e. Street and Number	gomery		TVCI L	10f. Zip Code			100 Ci	tizen of What C	ountry?	
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	e 23	Funeral	3214 Norbeck		edent Ever in U.S	13 1	209		n? (Specify Yes o		14. Race - Ami	erican Indian.	
	item de	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	orces?	j. 13. j	f Yes, specify Cub	an, Mexican,	n? (Specify Yes o Puerto Rican, etc.)	Black, Whi		
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Maryland	should be and Mental marked o umatic eve		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number	or Rural Route Nu	ımber, City	or Town, State,	Zip Code)	
Ξ	and 2 ealth a m 27 is		James J. Scull	Ly - Son		9022	Shinlea	f Cour	t, Colum	bia, l	Marylan	d 21045	
e G	of He item		20a. Method of Disposition	- 77		ace of Dispo	sition (Name of natory or other pla	сө)	Date	20c. L	ocation - City or	Town, State	
Ĕ	permit. Pages 1 and 2 should b Department of Health and Menti Important: If item 27 is marked any injury or other treumatic e once.		1 ☐ Burial 2 ☐X remation 4 ☐ Dopation 5 ☐ Other (S		Met	ropoli	tan Crem	atoriu	m 5/05/	07 A	lexandr:	ia, Virginia	
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<u> </u>	death certifica attending pt for use as t	Medi	IF FEMALE:									A GARAGE	
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. ^	14)		30. Name and address of person								J - J		
10), ,	-						er Dri	VP - #30	Λ P.	okwillo	20850	
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	Registr		Joseph M. Ha 31. Date filed (Month, Day, Year)	0 4 2007	Die	, ,,,	N. T.						

			For State Registrar	State of	f Maryland	l / Depa		t of H	ealth a		l Hygi	,	007	161	06	
	t. Pages 1 and 2 shr rtment of Health and rtant: If item 27 ie m njury or other traum	al	1. Decedent's Name (First, Middle, Last) HELEN K. SANTEE 2. Date of Death Month Day Year MAY 3 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea									2007	3. Time of E	Death M		
			ATLANTIC GENERAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15. Months Days Hours Min. (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) Months Days Min. (Months Days Months Months Months Months Months Months Months Months								9. Birth	Nace (State or otry) YLVANIA	Foreign A			
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nd		To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)									Code)				
Baltimore, Ma			KIM E. LAWRENCE 20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other (S 21. Signumer Lawreral Service	3 □Removal from	20b. Pla cer	ace of Dispo metery, crer ATORY	sition (Nan natory or o	ne of ther place ELMAI	e) RVA	Date 5/4/07	20	Dc. Locatio	LAND 2 on - City or To	own, State		
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed to Secure within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit on by	al Examiner	23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Due to (or as a consequence of):										reen			
		by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregnandirth 2 Fetal cant at time of deap	death 3	Ectopic pr						Date of delive	•	ear	
rds, P.		ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3								-	e to the cause of death? Probably 4 □Unknown				
al Records,		Completed									death?	opsy findings a mpletion of ca 22 No	vailable use of			
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Divi		sai Certifi	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)									9e <i>r</i> ,				
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,	Sta	ate.	30. Name and address of person Thomas July 31. Date filed (Month, Day, Year)	esti no	egistrar's Signatu	SUA	Print)		BER		no	218	11			
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	011101	100	1 - For Amend#26 Per Phy. Registrar Anne Anundel C	State of Ma . Health CM						Reg. No		16107				
В	Physici	an	Decedent's Name (First, Middle, Last) Robert James Tag						2. Date of D	Da	y Year	3. Time of Death				
	/Medi		4a. Facility Name (If not institution, give s	-			4b City Town	or Location of Death	Apr.	22	. 2007 County of Death	10:30a [™]				
	Examir	ier	4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center 4b. City, Town, or Location of Death Glen Burnie							1	Anne A	rundel				
	Funeral		Social Security Number 6. Sex	ocurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Da						Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country)						
9	Director		79 75 Yrs. Mar. 5, 1932									NY				
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other than "naturel", or items 23e or 28e-1 show other treumatic event, I'm Mydical Examinar must be notified at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Mar. 5, 1928 10d. in									10d. Inside City Limits				
		tor										1 ☐ Yes 2 🔯 No				
		Funeral Director	10e. Street and Number							10g. Cit	tizen of What Cou	ntry?				
		rai	448 Maryleborn Drive 21146								USA					
		une		Armed Forces?	Was Decedent Ever in U.S. 13. Was Armed Forces? 1 X Yes 2 No			Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or N Rican, etc.)	10-	14. Race - Amen Black, White,					
036	within 72 hours after ene. than "naturel", or Ite	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	II	1 ☐ Yes 2X No	Specify:			Specify: White						
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade	ucation de completed)		16a. Dec	edent's Usual Occu	kına	16b. K	b. Kind of Business/Industry						
121	Mithin hen hen	e Completed	Elementary/Secondary (0-12)	-)			during most of work									
2	be filed v tal Hygie d other t		17. Father's Name (First, Middle, Last)		V1C	e Preside	ent - Marl		le. Maiden	Aviation iden Sumame)						
Maryland 21215-0036	id be ental ked o	To Be	Robert J. Taggart						na Burke							
ary	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 te marked other than eny injury or other treumatic event, I. a. M. 80ce.	L	19a. Informant's Name/Relationship (Ty)	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and							ral Route Number, City or Town, State, Zip Code)					
			Mary Ann Taggart/	Wife		J		eborn Driv		_	erna Park, MD 21146					
Baltimore,	ges 1 If ite or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	ce	metery, cre	osition (Name of omatory or other pla	ace) Apr	ril 26,	20c. L	ocation - City or T	own, State				
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Box	eath c attend for us		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							11	23d. Date of delivery Month Day Year					
	the day the	ysic														
Division of Vital Records, P.O.	s that gned t	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobal							tobacco i	cco use contribute to the cause of death?					
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ecc	ne law r has be ge 2 sh	Certification: To Be Completed							24a. Wa	s an opsy	24b. Were auto	psy findings available impletion of cause of				
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Vita	To the Hospitel or Attending Physicien: The law requires that the death certificate be within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu		25. Was case referred to medical examiner? Hospital: Other: Othe							one)						
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ion	nding ath. r: Afte e fune		1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No								,,					
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	Hosp 24 hot Fune stely fi	Medicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of er: On the basis of e and manner state	xamınati	vledge, dea on and/or i	th occurred at the to estigation, in my	ime, date and place, opinion, death occur	and due to the tred at the time	e cause(s) e, date and) and manner as s d place, and due t	tated. o the cause(s)				
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Med	29b. Signature and Mo of certifier 29d. Date signed (Month,								Day, Year)					
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	- and		30. Name and address of person who co	mpleted cause of dea	ath (Item	23a) (Type	Print)	. 0	4	-9 4	, _ h	2 -11-				
	WHO	10	31. Date filed (Month, Day, Year)	32. Fraistran	's Signati	Zex	3 MEDIO	ero Par	LLWHY -	71 M	100 1	NNOTULE				
	Sta Registr		MAY 0 1 20	07 Serar	o orginali	H.	Secret)				IND.	4401				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Gracia E. Turkoff April 28, 2007 р м 4:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 11119 Stillwater Lane Kensington Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) District 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF 84 579-18-4291 Director of Columbia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11119 Stillwater Lane items 23a 20895 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White þ 3 Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Bennett Lorena Virginia Gissell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Turkoff-Son 10141 Spring Ivy Lane; Mechanicsville, VA 23116 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 5/4/07 Brentwood, MD 21. Signature of Puneral Service Licensed 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1040 Rockville Pike, Rockville, MD 20852 Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): physician Division or Vital Records, P.O. Box 68760 Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. **Other sIgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2x No 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 TResidence 6 ☐ Other (Specify) 2X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 🔼 Natural 5 Pending investigation s after dea... ral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signajure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 460) D0064615 05/01/07 10

State Registrar 31. Date filed (Month, Day, Year) MAY 03 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			For State	State of Ma	aryland		artment of F					000	-7	16	100
-			Registrar 1. Decedent's Name (First, Middle, I	l aet)	_		lilicate of	Dean		2. Date of De	Reg. No	<u> </u>	1 3	3. Time of	Death
П	Physicia	an								Month	Da	-		4 -	рм
	/Medic	0.00	Harry Par 4a. Facility Name (If not institution, g		t		4b. City, Town, o	r Location	n of Death	May 2		O7 County of D		:45	
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	Director		219-14-1409	1 x M 2 □ F	82	Yrs.	Months Days	Hours		Sept.				ylar	_
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	with the Marylanda or 28a-f show	ä	15300 Bitterro	ot Way				20853	3				JSA		
	eath rs 23 must	eral	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cub			cify Yes or No)-	14. Race - A	merican		
36	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No		If Yes, specify Cub 1 ☐ Yes 2 ☐ No			Hican, etc.)		Black, W Specify Wh		·.	
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Ba	permit. Pag Department Important: I any injury o		1 KenSKils	Consist		11.7	2. Name and Addr Francis								00001
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8	Dhysician		shock, or heart failure. List o	nly one cause on each III	ne.								0	onset and	Death
6	Physician /Medical		disease or condition resulting in death)	a. Respiration Post of the Pos			ıre						2_	Year	·s-
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	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the best Examiner: On the basis of	of examinati	neage, dea on and/or i	un occurred at the nvestigation, in my	ume, date opinion,	e and place, death occur	red at the time	e, date a	nd place, and	due to t	the cause	e(s)
	thin 2 the mplet	Medical	29b. Signature and title of certifier	and manner s	Idled.		29c. Licer	nse numb	er		29d. D	Date signed (M	Month, D	ay, Year)	
	7 ≥ 6 0		205, Organization and this or our inter-	west 1	1/		1	00379	92		May	2, 20	07		
	iD+1		30. Name and address of person v	who completed cause of	death (Item	23a) /Type	Print)								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 4:35 AM Joseph Franklin Twilley 2007 May 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown 8. Date of Birth (Month, Day, Year) April 2, 1935 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 214-34-7029 1 X M 2 □ F 72 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more or 28a-f show once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland St. Mary's Hollywood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 24415 Morgan Road 20636 USA Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 K No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Government Elementary/Secondary (0-12) College (1-4or 5+) Plumber Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Franklin Twilley Lydia Jane Bowie ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24415 Morgan Road Hollywood, MD 20636 Ada Joy Twilley / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12 2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, F P.O. Box 270 Leonardtown, MD 20650 P.A. 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CARMOVASCULAR INTEASE Onset and Death Immediate Cause (Final disease or condition resulting in death) ATMGLOSCLEPUTIC Physician /Medical Due to (or as a consequence of): YFARS Examiner MRTERY CRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ρ MILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy perform 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. al Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year) MAY 1 0 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder Gill, M.D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

56096

29d. Date signed (Month, Day, Year)

5-10-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No, 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year () **Physician** 0924AM awrenu Ivace 07 ILCSH 02 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll cuminston HUSPI RU arroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1**X** M 2□F Yrs 88 Director 215-16-0487 4/4/1919 Maryland Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show a notified at 1 ☐ Yes 2X No Director Upperco Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with pe o United States 21155 5406 Arcadia Ave. r than "natural", or items 23a the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 <u></u> 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. Hygiene. PBX Installer event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 Is marked ot traumatic ever Ivy Jane Thompson Columbus Tracey ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16305 Hanover Pike Upperco, MD 21155 permit. Pages 1 and 2:
Department of Health as Important: If item 27 Is any Injury or other trau Gladys M. Smith - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Wesley Cemetery Hampstead, Maryland 5/5/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home, 934 South 21. Signature of Funeral Service License M001490 Main Street, Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed sifter death. use as the burial-transit arehom and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, nding physician BAILLAHOU Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy perform 2 N6 1 🗌 Yes 2 No certificate 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral o 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Twentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature -0054218 05-02-2007 NI 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

NR. Raman B Kanena 319 Mel culm dure, West minitor, FID 21157)

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State Registrar 32. Registrar's Signature

31. Date filed (Month, Day, Year) MAY 0 3 2007

Kamar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death , 2007 Year April 28 **Physician** Dennis William Tieman 2:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster
If Under 1 Year | If Under <u> Carroll Hospital Center</u> Carroll Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 1**XX**M 2□ F Months Hours Min. 213-44-0068 Director 64 26. 1943 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Directo Carroll MD Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5240 Stone Bridge Way 21784 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify Specify: White Completed by 3 Widowed 4 Divorced 1964 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Northrop Elementary/Secondary (0-12) College (1-4or 5+) Logistician Grumman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin N. Tieman ၉ Dorothy Rowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Tieman(wife) 5240 Stone Bridge Way Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Wesley Freedom Cem 5/1/2007 Sykesville, MD 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCUD Physician 8417 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ∏ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier AVI+ OI LACK

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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3. Registrar's Signature

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar	cate of Death	Reg	. No		
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	4a. Facility Name (if not institution, giv 8119 Hicks Road Apt C	e street and number)	4b. City, Town, or Lo Jessup	cation of Death	4c. County of Death Howard	h
Funeral Director	5. Social Security Number Control of the Security Number Con	X 7. Age (In yrs. last bi	rthday) If Under 1 Year Months Days (If Under 24Hrs. 8. Date of Birth Hours Min.		ountry)
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Baltin permit. P Departme Importar injury or	21. Signature of Funeral Service Licer	prout	22. Name and Address of	FEGOILITY WILKERSON Avenue, Peter	Funeral Esburg, VA	stablishment 23803
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. The law requires that the death certificate be executed to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Electical Certification:	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of death	2 Fetal death 3 5 Other (Specify)	Ectopic pregnancy	Month	Day Year
of Vital Records, P.O. Box 68 ing Physician: The law requires that the death certify After this certificate has been signed by the attending tuneral director, page 2 should be detached for use as my To Be Completed by Physician	Part II. Other significant conditions	9 Olikhowii	ing in the underlying cause giv		pacco use contribute to	the cause of death?
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Division of Vital Records, tall or Attending Physician: The law requir as after death. The law requir and price or the state of the funeral director, page 2 should led in by the funeral director, page 2 should bertification: To Be Completed	27. Manner of Death		o. Time of Injury 28c. Injury	at Work? 28d. Describe h	ow injury occurred	
Division c ppiral or Attending rours after death. Tilled in by the fun Certification	1 X Natural 5 Pending 2 Accident Investigation	28e Place of Injury - At home	, farm, street, factory, office but	es 2 No 28f. Location (S	treet and Number or F	Rural Route Number, City
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Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page Medical Certification: To Be Con	298 (611116)	ian: To the best of my knowledge, or; On the basis of examination and/or and manner stated	or investigation, in my opinion, o	death occurred at the time, date a	and place, and due to	the cause(s)
F × F 8	29b. Signature and title of certifier	Youll	29c License O.C.M		April 7, 2007	onth, Day, Year)
	30. Name and address of person who	ssistant Medical Examiner	111 Penn Street, Ba	ltimore, MD 21201		
State Registra	31. Date filed (Manth Day, Year)	32. Registrar's Signature	pole			

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Apr. 27, 2007 11:15 p Mont			1	For State of Maryland / State of Maryland / Registrar	Department of H Certificate of I			ene eg. No. O O O 7	
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Document of Discontinued Control of Secretary Con				5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, OCT • 10		nplace (State or Foreign
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20. Meroud of Disposition (Name of Date and Disposition (Name of Land Date and Disposition (Name of Land Date and Date a	2	should nd Me mark mark	ĭ	<u>-</u>	19b. Mailing Address (Street	and Number or Rur	al Route Number	; City or Town, State, 2	Zip Code)
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Physician Modical Examiner 23a. Farth. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. 23a. Farth. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause Final Examiner 3a. Succeptibility list conditions, if any legality is conditions in the past 12 promises of the property of the initiation devents by the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiation of the initiat	more	SET		1 M Burial 2 Cremation 3 Hemoval from State		May	2,	•	
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State Stat	on or	ding Phy h. After thi		1 Matural 5 □ Pending (Month, Day Year)			28d. Describe ho	ow injury occurred	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Whish Markan 30 S Hospital W. Glan Burnie, MD 21061 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature		e Hospital 24 hours e Funeral etely filled		(Check only 2 Medical Examiner: On the basis of examination	edge, death occurred at the tien and/or investigation, in my	ime, date and place opinion, death occu	, and due to the c rred at the time, c	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
State 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature		To the within To the comple	Me		29c. Licens	se number 3950	5 /	29d. Date signed (Mon	th, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature	ţ	Mail		30. Name and address of person who completed cause of death (Item 2	(3a) (Type, Print)	v. Glo	n Bur	rie MD	21061
				31. Date filed (Month, Day, Year) 32. Pegistrar's Signatur	re				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>007</u> 29, Robert Keith Warner April 10:15am 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Holy Cross Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) Days Hours Months X⊓M 2□F 83 Feb 21,1924 578**-**09-8532 Iowa Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County MD 1 X Yes 2 □ No Colesville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13217 Locksley Lane 20904 Unites States 12. Was Decedent Ever in U.S.
Armed Forces? 07-1944
1 5 × s 2 □ No
If Yes, Give
Year or Dates: 03-1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 03 - 1946White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Dept Of US Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry William Warner Nellie Rowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Richards Warner/Wife 13217 Locksley Lane, Colesville, MD 20904 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-02-07 4 □ Donation 5 □ Other (Specify) National Crematory Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Myocardial Infarction
 Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Parkinsonism 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypercholesterolemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 💢 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner'

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

should be filed within 72 hours after death with Ind Mental Hyglene. marked other than "natural", or Items 23a or: matic event, the Medical Examiner must be.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofthe any injury or other traumatic event, once.

Baltimore, Maryland 21215-0036

Box 68760, certificate be

P.O.

Division or Vital Records,

Physician:

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Director

Funeral

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Completed

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death with the Maryland

Examiner attending physician and for use as the burial-tran Physician/Medical n signed by the a ld be detached f Completed by peen cate has page 2 s certificate Be P this funeral Certification: After

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29c. License number

DC 6165

29d. Date signed (Month, Day, Year)

April 30,2007

ours after death.

neral Director: A
filled in by the fu

To the Hospital within 24 hours a To the Funeral C completely filled Hospital

> Mary D. Restifo M.D. 3301 New Mexico Ave, N.W. Washington DC 20016 31. Date filed (Month, Day, Year)

30. Name and address of person who completed buse of death (Item 23a) (Type, Print)

Mestys

State Registrar

Medical

03 2007

nary

29b. Signature and title of certifier



			1 = For State Registrar		Marylar	nd / Depa	artment rtificate				F	Reg. No.	007	16116	ŀ
	Physici		1. Decedent's Name (First, Middle, DELPHINE B.	Last) WARFIEI	JD OIL						2. Date of Dea Month MAY	Day 2	2007	3. Time of Death 5:50 A M	И
	/Medic		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	f Death	1.T.T.	-	County of De		_
		Ť	WILSON HEALTH	CARE CENT	TER		G	AITH:	ERSBU				MONTG	OMERY	
L	Funeral Director		579-52-0045	3. Sex 1 □ M 252 F	7. Age (<i>In yrs</i> . 67	(ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day July 27	, Year)		irthplace (State or Foreigi Country) 7irginia	n
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits	5
	Mary	tor	Md. Monte	gomery		Gaith	ersbu	rg						1 □ Yes 2 X No	٥
	3a or 28s	i Director	10e. Street and Number 20800 Woodfield	d Road			10f. Zip	Code	2088	2		-	en of What (Country? States	
250	s 1 and 2 should be filed within 72 hours after death with the Maryland fleatist and Mental Hygiene. I fleatist and Mental Hygiene. Other traumstic event, the Medical Exactical must be notified at other traumstic event, the Medical Exactical must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 ⊠ No e		Was Deced If Yes, spec	,	spanic Orig n, Mexican, Specity:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		4. Race - Am Black, Wh Specify:	nerican Indian, lite, etc. White	
200	thin 72 hor e. an "natura Medicul I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		-4or 5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done di e retired)	tion uring most	of working	g	16b. Kin	d of Busines	s/Industry	
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yiaii	should be fill nd Mental H marked otl	To Be	17. Father's Name (First, Middle, La Delfin Belen	(st)						llie	(First, Middle, Clor		Sumame)		
_	ゥモトコ		19a. Informant's Name/Relationship John T. Warfie		lusband		•				Route Numbe			Zip Code) 1. 20882	
ע	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tre once.		20a. Method of Disposition 1 🖽 Burial 2 ☐ Cremation 3 ^ 4 ☐ Donation 5 ☐ Other (Spe		State	Place of Dispo cemetery, crer elsvil	matory or ot	her place	.)	Da 5/5/				or Town, State	
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<u> </u>	Depariment of the part of the		> murief H	· Bar	hen						r Funer Layto			id. 20882	
F	hysician		23a. Part1. Enter the disease, or conshock, or heart faiture. List or timmediate Cause (Final disease or condition resulting in death)	nly one cause on ea	ach line.	th. Do not ent	er the mode	of dying	, such as c				·	Approximate Interval Between Onset and Death 2 Months	
,007	Cate be executed by Science be executed by Science and burial-transit sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. AD Due to (PENOCAR or as a consec	CINOMA quence of):	OF LU	JNG							
.O. DOA	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⑤ No 9 □ Unknown		irth 2 ☐ Feta ant at time of d	aldeath 3	Ectopic pre Other (spe				- Talle de la comp eta de la competa de la	2	3d. Date of d Month	elivery Day Year	
U3,	pures that r signed to lid be det	by	Part II. Other significant condition BREAST CARC		eath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to			to the cause of death? Probably 4 Unknown	ח
2	aw requir s been si 2 should	piete	ANEMIA OF C	HRONIC DI	SEASE						24a. Was		24b. Were a	autopsy findings available	8
	ysician: The lav is certificate has director, page 2	Completed	OSTEOPENIA (GASTRITIS	5						autop perfor 1 Yes	med2 2 No	death?	completion of cause of s 2 No	
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DIVID		Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At h	ome, farm, str fy)					3f. Location (S City or Tow		Number or F	Rural Route Number,	
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	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number		4	29d. Date	signed (Mor	nth, Day, Year)	
j	4		14. Rekert	bira	lika	du	es	004	4115			М	AY 2,	2007	
ı	(30. Name and address of person with H. ROBERT BIRS	CHBACH, M	1.D.	201 R		L AVI	E., G	AITHI	ERSBURG	, MD	. 208	377	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3	2007	egistrar's Sign	t do	set !								

			1 - For State Registrar	State of Maryla	and / Dep	artment o	of Health	and Me	ental Hyg	iene	007	161	17
	Physici	20	Decedent's Name (First, Middle, La.	st)					2. Date of Dear Month	h Day	Year	3. Time of D	eath)
	/Medic			WEISS		T			APRIL	29	2007	5:50	Рм
	Examin	ěr	4a. Facility Name (If not institution, give				vn, or Location	n of Death			ounty of Death	• -	
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	Funeral Director			CM OFF	88 Yrs.		ays Hours	Min.	OCT. 7,	Year)	B PENN	SYLVANI	
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3	al', o	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣	No Specif	y:		S	pecify: WHI	TE	
315-0036	thin 72 hours e. an "natural", Maylea Ex	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	edent's Usual O	ccupation	ost of workin	ea l	16b. Kind	of Business/In	dustry	
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O. Box 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pra 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregr □ Other (<i>specil</i>				23	d. Date of delive Month	ary Day Ye	ar .
1	s that ned b	by Pt	Part II. Other significant conditions	ontributing to death but not	resulting in the	underlying caus	e given in Par	t I.	23e. Did to	bacco use	contribute to t	he cause of dea	ath?
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Vital		Be C	25. Was case referred to medical				26. Pla	ce of Death	(Check only or			20110	
> 10	Physiclan: r this certifica ral director, p	To	examiner? 1 ☐ Yes 2 PNo	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatie	nt 3 DOA	Other:	Nursing Hom	ne 5 ☐ Resido	ence 6[Other (Specia	(y)	
	D e e		27. Manner of Death 1 Natural 2 Accident 2 Accident	28a. Date of Injury (Month, Day Year	28b. Time of Injury	of 28c.	Injury at Work?		8d. Describe h	ow injury o	occurred		
DIVISION	s after de s after de al Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined		At home, farm, st ecify)	reet, factory, of	ffice	2	8f. Location (Si City or Town		Number or Rura	al Route Numbe	e <i>r</i> ,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier	ysicien: To the best of my niner: On the basis of exam and manner stated.	knowtedge, dea nination and/or it	th occurred at the nivestigation, in	he time, date a my opinion, de	and place, a eath occurre	nd due to the c d at the time, d	ause(s) ar ate and p	nd manner as s lace, and due to	tated. the cause(s)	
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	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Snach)							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nő. 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Day **Physician** 13:45 PM 25, PHILIP MARVIN WEIKERT APRIL 2007 /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□ F Yrs. Director JANUARY 1,1919 PENNSYLVANIA 198-07-8701 88 Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "naturel", or items 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 X No MARYLAND QUEEN ANNE'S STEVENSVILLE Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 215 MCKAY ROAD UNITED STATES 21666 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 20 Yes 2 □ No ff Yes, Give Year or Dates: 1942—1946 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ SELF EMPLOYED SALES permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CHARLES WEIKERT NORA STOVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 215 MCKAY ROAD, STEVENSVILLE, MARYLAND 21666 LAURA WEIKERT/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition APRIL 26. 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 CHESAPEAKE CREMATION STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Part1. Enter the disease, or complication, tha caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Onset and Death fmmediate Cause (Final disease or condition resulting in death) rneumon, c **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and -trans Due to (or as a consequence of) ettending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1☐Live birth 2 Fetal death Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) Physic the 1 Yes 2 No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 nknown 1 Yes 2 No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has certificate 1 Yes 2 - No To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death |Check only one) examiner? Hospital: 1 - In patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28d. Describe how infury occurred Certification: 28c. Injury at Work? 1 aturaf 5 🗌 Pendina 1 ☐ Yes 2 ☐ No М investigation 2 TAccident upletely filled in by the Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and til D00058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parking Annaplis 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Dav Year **Physician** P^{M} EDWARD JOSEPH WILSON 2007 Mav 4:33 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea, Feb. 14, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□F Months 579-46-6539 71 D.C. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐Yes 2 ☑ No Montgomery Director Maryland Dickerson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code P 0 Box 208 20842 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Vietnam Specify. Specify: 2 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. "Important: If Item 27 is marked other than "I any Injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Revenue Agent IRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Titus Wilson Ethel Mildred Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Wilson / Wife P O Box 208, Dickerson, MD 20842 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Smithsburg Crematory 5/3/2007 Smithsburg, Maryland 22. Name and Address of Facility
ROBERT E. DAILEY & SON FUNERAL HOMES, 21. Signature of Funeral Service Licer KUBERT E. DALLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on your cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiovascular Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Ö signed by the 9□Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 1□ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

Division or Vital

State

Registrar

Medical

30. Name and address of person Harry Bigham

of certifier

29a. Certifier

(Check only one)

29b. Signature and title

31. Date filed (Month, Day,

n who completed cause of death (tem 23a) (Type, Print) 6410 Rockledge Drive, Bethesda, Maryland 20817

gistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D38888

29d. Date signed (Month, Day, Year)

May 2, 2007

07-03282 DeShaun White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eShaun White		State of Maryland / 1- For State Registrar		irtment of <i>tificate of</i>			Menta	al Hyg	giene	Reg. No.	20	07 1612
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) De Shaun D. White							. Date of D Month	Day	Year	3. Time of Death 0041 hrs
neuicai Examiii		4a. Facility Name (if not institution, give street and number)		- 4	4b. City,	Town, or Lo	ocation of		April 30		. County of De	
		Sinai Hospital			Balti	more Cit	у					
Funeral			e (In yrs. Ia	ast birthday)	If Und	der 1 Year	If Under	24Hrs. Min.	8. Date of	Birth(MM/		Birthplace (State or eign
Director		220-84-9397 1X M 2 F	31	Yrs		ilis Days	Hours	IVIIII.	Aug 1	1, 1	975	Country) MD
śu		Usual Residence of Decedent 10a. State 10b. County "	10c. City,	Town or Locati	ion							10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	_	MD Wicomico	Sa	lisbury	7							1 Xes 2 No
daryła 28a-f g	ector	10e. Street and Number				p Code				10g. Citi	zen of What C	ountry?
h the N 3a or	Dire	207 Truitt St.				21804					USA	
eath with the Maryland items 23a or 28a-f sho ust be notified at once	neral	11. Marital Status 1 Never Married 2 Married Armed Forces?				lent of Hispa ify Cuban, I				No-	14. Race - An White, etc	nerican Indian, Black,
rer des	Fun	3 Widowed 4 X Divorced If Yes, Give Year	X No		Yes :	2 X No	specify:				Specify: B	ack .
ours al atural	g p	15. Decedent's Education (Specify only highest grade com	ipleted)	16a. Deceden	nt's Usua		n (Give kir				Kind of Busine	
5-0036 led within 72 hou tygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5	5+)	during m	iost of we		O NOT U	se reure	u)	ı		,
4 withi	틹	12 17. Father's Name (First, Middle, Last)				n/a	3.Mother's	Name (I	irst, Middle	e. Maiden	N/ Surname)	a
₹ = ± 8 5	e B	Gregory J. Wallace							ne Wh		,	
Z 5 6 2 9	٩	19a. Informant's Name/Relationship (Type, Print)									•	ate, Zip Code)
- P = E = E	1	Jacqueline White/mother 20a. Method of Disposition	20b.	207 T		t St.			oury,			or Town, State
Pages 1: Pages 1: nent of H ant: If it		1 X Burial 2 Cremation 3 Removal from Sta	ite (crematory or oth	her place	e)						
Baltimore, permit. Pages I at Department of Het Important: If ite Important: If ite	ł	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Gr	een Acr	lame an	d Address o	of Facility	-	2007		alisbur	Ty, MD
Perr Perr Perr Injury	1	Talara Detatron		Le 16	wis 18 V	N. Wa Vest R	itson Rd	Fun Sali	eral .sburv	Home MD	21801	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death	. Do not enter t	he mode	of dying, s	uch as car	diac or i	espiratory	arrest, she	ock, or heart	Approximate Interval Between Onset and
vaminer	İ	Immediate Cause (Final disease or condition resulting in death) a. gunshot wound Due to (or as a conse										Death
		Sequentially list conditions, b.	equence o	1):								
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60, nte be ex hysician e burial	Nedical	UNPENDED AMENDED								100	d Data of dath	
of Vital Records, P.O. Box 68760, g Physician: The law requires that the death certificate be executed ther this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - trans	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcon	ne of preg		tal death	n 3 [Ectopic p	oregnan	Су	23	d. Date of deliverselves Month	/ery Day Year
Box 6 e death ce the attend	ا س	1 Yes 2 No 9 Unknown 9 Unknown	time of de	eath 5 Ot	her (Sp	ecify)				1		
D. B. t the de by the	튑	Part II. Other significant conditions contributing to death	but not r	esulting in the u	underlyin	ng cause giv	en in Part	: l.	23e. Di	tobacco	use contribute	to the cause of death?
i, P.O.	d b								1 🔲	es 2	No 3 F	Probably 4 🗸 Unknown
rds v requi	Completed								24a. W	as an topsy		autopsy findings available to completion of cause of
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Vital Records, systeian: The law requir this certificate has been stirrector, page 2 should lairector, page 2 should la	Be	25. Was case referred to medical examiner? Hospital: 1 Inpution				26.Place c	thor:		-			
of Vita ling Physicia After this cer	의	1 Yes 2 No Inpatie 27. Manner of Death 28a. Date of Inju		ER/Outpatient 28b. Time of I		DOA 28c. Injury			Home 5		ence 6 O	her:
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Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fur	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	jury - At h	ome, farm, stree	et, factor	ry, office bui	ilding, etc.	2	8f. Location	(Street a	and Number or	Rural Route Number, City
Division At ours after dours after direct filled in by	E	4 Homicide determined (Specify) Loc	al Stree	et				3	630 Reist	erstown	Road, Baltim	ore City, Md.
		29a. Certifier 1 Certifying Physician: To the best of mone) Certifying Physician: To the best of mone Certifying Physician: To the basis of examiner: On the basis of examine										
To t With To t	Medical	and manner stated. 29b. Signature and title of certifier				9c. License						Month, Day, Year)
		1/1/1/	/			O.C.M	.E.				il 30, 2007	,
	}	30. Name and address of person who completed cause of d		,	<u></u>			-				
		Theodore M. King, Jr., MD. Assistant M			111 P	enn Stre	et, Balt	imore,	MD 212	01		
Sta	te	31. Date filed (Month Day, Year) 3 2007 32. registra	r's Signatu	ire for	alle)	,						

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30, April 2007 5:15a Leonard Calvin Yates /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charlotte Hall St. Charlotte Hall Veterans Home Marys 8. Date of Birth (Month, Day, 01/21/ Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** Days 57 Director 212-54-3712 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ahow Yes 2 No Director Charles LaPlata Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20646 USA Ітете 23а 12925 Yates Place Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 69 – 71 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic avant, the Medical Exemption 1 Never Married 2 Married Specify: Black 1 Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Defense Department 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenifer Joseph Lillian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12925 Yates Place LaPlata, Maryland 20646
ace of Disposition (Name of Date 20c. Location - City or Town, State Joyce Yates/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans 5/8/2007 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Funeral Home PA 07 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a cons Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a cons P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an enne autopsy 2 X No 1 Yes certificete Division of Vital or Attanding Physicien: within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death

1 X Natural

2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert 3067 D0057574 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5920 Willow KNOII DRIVE Hhmaci 32. Registrar's Signature 31. Date filed (Month) State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 02:57 A MAY 2007 ROBERT ELMER ZINN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 84 Yrs. Director 290-14-4096 OHIO Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Mudical Examiner recovers. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo SUSSEX SELBYVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19975 USA 37143 E. STONEY RUN Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No
If Yes, Give
Year or Dates: 1944-46 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: WHITE Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SPECIAL AGENT FBI17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELMER ZINN ဂ္ဂ PEARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA C. ZINN/WIFE 37143 E. STONEY RUN, SELBYVILLE, DE. 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CREMATORY OF DELMARVA * 4 □ Donation 5 □ Other (Specify) 5/4/07 DELMAR, DELAWARE A Juneral Service Licenses 21. Signatur 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part / Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician 45CKD TEM MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760. by Physician/Medical as attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy 2 Fetal death Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 🗀 Inpatient ဂ္ 2 KER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHY ZINORTH 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 04 Registrar 2007

2/19/1923 - 5/3/2007

Robert

Zinn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Physician 0649 M ADEOAYO BABATUNDE May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Hospital Hopkins last birthday Birthplace (State or Foreign Country) **Funeral** Days **X** M 2 □ F 214-47-6071 Director Nigeria Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Tyes 2 No **Funeral Director** MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o a 9404 Jodale Road 21133 Nigeria Pages 1 and 2 should be filed within 72 hours after death w nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a Iny or other traumatic event, the Medical Examiner must is . Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Nigerian 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Entreprenuer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel A. Adedayo <u>Omogbenuade Adeojo</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Babatunde Adeniran Adedayo 9404 Jodale Rd., Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Important: If any Injury or Family Cemetery 5/26/07 Lagos, Nigeria 4 □ Donation 5 □ Other (Specify) 21. Signatur of Fineral Service L 22. Name and Address of Facility Wylle F/H F.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** negative three clays Gram /Medical Due to (or as a consequence of): **Examiner** Hospital Seven days Sequentially list conditions, if any, leading to him editions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last acquired Examine The law requires that the death certificate be executed Idispathic pulmenon Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician a Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗡 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 State

Registrar

29b. Signature and title of certifier

BRIAN GARIBALDI

31. Date filed (Month, Day, Year)

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Carle B

600 North Wolfe Street Balkmure MARCHUMB 212F7

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

Johns Hopkens

2007

Hospital or Attending Physician: in 24 hours area courties the Funeral Director; Af To th. within 2-

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DR. DAVID DUNN

31. Date filed (Month, Day, Year)

Medical

State

615 W.MACPHAIL ROAD - BEL AIR, MD 21014

and manner stated.

32. Registar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

032275

29d. Date signed (Month, Day, Year)

man 16, 2007

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2007 16126

		For State	Certifica	ate of Death	Reg. No.	3. Time of Death
Physician		Decedent's Name (First, Middle,Last)	1		Month Day	Year 0900 hrs
Examine		Serena B	yrd	the Direction of Death	May 14, 2007	unty of Death
	4a	. Facility Name (if not institution, give stre	et and number)	4b. City, Town, or Location of Death Baltimore	"	
		Johns Hopkins Hospital			a la Date of Birth/MM/DD/	YYYY) 9. Birthplace (State or
Funeral	5.	Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24Hr Months Days Hours Mir		Foreign
Director	1	18-98-9525 1 M	2× F 28	Yrs.	05/10/197	Country)
	_	sual Residence of Decedent				10d. Inside City Limits
έ		Da. State 10b. County	10c. City, Town			1 X Yes 2 No
_ & &		W.D.	Balt	imore		
ylanc one	<u> </u>	De. Street and Number	Λ	10f. Zip Code	10g. Citizen	of What Country?
Mar r 28s	10 LG	-AC A/ 1 1/	and Aranie	21205		JSA I
death with the Maryland or items 23a or 28a-f show any must be notified at once.		508 N. Lakewa	. Was Decedent Ever in U.S.	13 Was Decedent of Hispanic Origin? (Race - American Indian, Black,
h wit	runeral 1		Armed Forces?	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.
deat or its	[]	1	Yes 2 No	1 Yes 2 No specify:	Sp	ecity: Black
after iner		Widowed 4 Divorced If Ye	Jates:	Decedent's Usual Occupation (Give kind o		of Business/Industry
hours afte "naturaf",	Completed by	15. Decedent's Education (Specify only h	College (1-4 or 5+)	during most of working life. DO NOT use re	etired)	\mathcal{A}
136 hin 72 h ie. than "1	je	Elementary/Secondary (0-12)	College (14 of 51)	Cashier	Tal	pa Johns Tizza
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21215 wild be fill Mental H marked ic event, t	å [Horace C. R	Dyra 11	9b. Mailing Address (Street and Number of	or Rural Route Number, City	or Town, State, Zip Code)
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Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Denation 5 Other Specify:	Chui	rch Cemetery 5	121107 Day	sidsonville, MD ne Funeral Services
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Balti permit. Departm Imports injury o	T	Vaugha (1. R	heere	15151 Batto. Nat'l 4.	Ken Ka HOMOVY	MU LILLI
ysician	+	23a. Part I. En le the disease, or complica	itions that caused the death. Do	not enter the mode of dying, such as cardia	ac or respiratory arrest, shoc	k, or heart Approximate Interval Between Onset and
/ledical	- 1	failure. List only one cause on each	eizure disorder			Death
Examiner			e to (or as a consequence of):			
	- 1	b.				
	<u>a</u>	Sequentially list conditions, if any, leading to immediate	e to (or as a consequence of):	- + +		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
_	<u>7</u>	events resulting in death) Last Du	e to (or as a consequence of):			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be expiting 24 hours after death. To the Hospital Attended After this certificate has been signed by the attending physician to the Function: After this certificate has been signed by the attending physician confinely filled in by the funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	d	23c. If yes, outcome of pregnand Live birth 4 Pregnant at time of death 9 Unknown contributing to death but not result 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home (Specify) In: To the best of my knowledge. On the basis of examination and and manner stated.	26.Place of Death \Cr 26.Place of Death \Cr R/Outpatient 3 DOA Other, 3 Ectopic present to the underlying cause given in Part L. 26.Place of Death \Cr R/Outpatient 3 DOA Other, 1 Yes 2 N 28c. Injury at Work? 1 Yes 2 N 29c. License number O.C.M.E. 3a) 111 Penn Street, Baltimore, M	23e. Did tobacco of 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 N Neck only one) Rursing Home 5 Reside or Town, State) 28f. Location (Street a or Town, State) e, and due to the cause(s) all arred at the time, date and pl	Month Day Year use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? o 1 Yes 2 No ence 6 Other: ury occurred and Number or Rural Route Number, City and manner as stated. ace, and due to the cause(s) Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** DOROTHY BOWLEND MAY 13 2007 7:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1□ M 2 F Director 20 Brookl Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location iral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Tores 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give. Year or Dates: Specify Completed by 3 Widowed 4 ☐ Divorced 'natural', Whi the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use petired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State revalChapel-BelA/ 115/01 5 ☐ Other (Specify) 4 Donation rocest 22. Name and I dress of Facility 3 New sport De, Foresthil, mozius 21. Signature of Funeral Service notu 23a. Part1. Enter the disease shock, or heart failure. cations that caused the Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-trans Box 68760,⁷ Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9☐Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 **5**00 1 Yes 1 Yes Division or Vital un To the Hospital or Attending Physician: Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဥ 1 Yes 1 🔲 Inpatient After this of 2 ☐ ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 2 Accident 1 Yes 2 No within 24 hours after death

To the Funeral Director: / 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

n

31. Date filed (Month, Day, Year) 32. Registra

DR. PETER LOPRESTI -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

N 1 8 2007

1308 BUSINESS CENTER WAY, SUITE 102 - EDGEWOOD, MD 21040

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Roscoe Kenneth Buck 04: 32 PM 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SQUARE Franklin Koseda le If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year June 16, 1 9. Birthplace (State or Foreign **Funeral** Hours XXM 2□ F Months 216-30-6431 72 Director June 1934 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Maryland Baltimore Middle River 1 ☐ Yes 2 CXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 Fuselage Avenue 21220 Funeral U.S.A. items 23a 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2 ☑ No Specify. þ unk. Specify: 3 Widowed 4 □ Divorced Year or Dates: White Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roscoe Harold Buck Hettie Pearl Hutchinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Harold Buck (Son) 2005 Oakland Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H XIX Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 05/21/2007 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A Signature of Funer Service Livensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immedia Cause (Final **Physician** disease + condition resulting in death) /Medical to (or as a consequence of): Examiner ration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed ig physician ar as the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a d be detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 1 ☐ Yes 2 🗌 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 autopsy certificate har irector, page 2 perforr director 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner' 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) 9000 Frankling 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAY 1 8 2007

Registrar DHMH 17 Rev 1/2001 May 15

600 North Wolfe Street, Baltimore MD 21287

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

Sarah Skelton, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/5 THE COOK OF 125/117 WS Mental Hygiene
State of Maryland Department of Health and Mental Hygiene

Amend Item 25 per verb., 8867 mildate 1076 bb.

Reg. No. 2 0 0 7 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BROWN Physician Month 0505AM 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore handoustaun er i Year I II Under 24 Hrs. 8. Orthwest Hospital 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number 8 **Funeral** Months 1 □ M 2 KF Hours Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 ☐ Divorced Completed marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Adjustor Mich Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 Is marked o 2 <u> Iteuenson</u> traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Lo Gwendolun Shawl MD 21207 *Soughki* 20a. Method of Disposition 20c. Location - City or Town, State Important: If It any Injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Masary Cometry 05:12.07 Dundalh MD 22. Name and Address of Facility Vaugha C. Gireche fune. on Sovice 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Moad Mandalistain mo 21133 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any the ding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): the burial-Division or Vital Records, P.O. Box 68760, physician as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) as been signed by the a 2 should be detached 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CoRomany FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed' 1□ Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Hipatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 TYes 2 TNo s after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D To the Hospital 1 🖰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 54288 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kamasuany 31. Date filed (Month, Day, Year)
MAY 1 8 2007 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Patricia B₁om 8:46 P.M May 16 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Health & Rehab. Howard Ellicott City 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Months 212 22 6570 81 Director 1926 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits id other than "natural", or Iteme 23a or 28a-f shorevent, the Medical Examinar must be notified at 1 Tyes 2 X No Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6058 Ritchie Highway U.S.A. Funerai 21061 Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Iteme 23, and other fraumatic event, if a Medical Eventian multy or other fraumatic event, if a Medical Eventian multy. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christopher Cole Mary Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Washington Street Cumberland, Maryland 21502 Christian Blom / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any njury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/19/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Juneral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Vari1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician COLON CANCER. 5 MONTHS /Medical Due to (or as a consequence of): Examiner QWONTHS CVA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician e I be detached for use as the burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. 1 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Completed has been si e 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page this certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. 1 Tes 2 No investigation 2 Accident efter death Director: , in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours eff To the Funerel D completely filled in the Hospital Medicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO063166 200 7 MD21228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERCY P. JACKSON , C, MAIDEN CHOICE LANE CATONSVILLE ,720 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:00 p. **Physician** May 13, 2007 Year Emily W. Brown /Medical 4b. City, Town, or Location of Deathonsville 4a. Facility Name (If not institution, give street and number, 4c. County of DBaltimore **Examiner** Frederick Villa Nursing Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth 7. Age (In yrs. last birthday) 6 Sex **Funeral** Birthplace (State or Foreign Countdaryland 1 M 2 F Days 218-14-6000 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Catonsville Baltimore 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10g. Citizen of What Oomtox? 10f. Zip Code 21228 711 Academy Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

Teachers Aide Elementary/Secondary (0-12) College (1-4or 5+) Education 18. Mother's Name (First, Middle Maiden Syrname) Jennie Belle Unglesbee 17. Father's Name (First, Middle, Last) Be William E. Wachter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Fural Faute Number Sitted 24099ete, Zip Code)
11803 Snerbourne Dr. Timonium, Maryiand 24099ete, Zip Code) Daughter Ms. Joyce brown ate 05/17/07 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Patuxent Cemetery of Mt. Carmel nshur Mo 22. Name and Address of Facility Home, P.A. Signature of Funeral Service Licensee Mundellen 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) VESCUlar /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entire U.S., if Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Year □Yes 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 known Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed' 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕽 📢 o 1 Inpatient Other: 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Injury 1 Natural 5 Pending investigation 2 Accident 1 TYes 2 □No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar 29b. Signature and title of certifier

Vaymore Willi-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mani

Smet

32. Registrar's Signature

DHMH 17 Rev 1/2001

200

Synt e

29c. License number

D47683

Rentestown

29d. Date signed (Month, Day, Year)

5/15/07

MD

DHMH 17 Rev 1/2001

State Registrar P.M.

00:9

2007

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CLOWSER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 7

			For State Registrar		State of Ivia	ai yiailu /		tificate of				Reg. No.	2007	15135
	Physicia	an		ne (First, Middle, La							2. Date of Dea Month	Day		3. Time of Death
	/Medic	al			ve street and number)			4b. City, Town, o	r Location	of Death	MAY 11		007 County of Death	9:45 p
	Examin	er		_	rsing home			Sandy	Spri	ng			Montgome	ery
	Funeral		5. Social Security N			e (In yrs. last b		If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birti (Month, Day	h y, Ye <i>ar</i>)	9. Birth	nplace (State or Foreign untry)
	Director		184-18-9		1□ M 2□ F 8	4	Yrs.				Aug. 26	, 1	922 New	Castle, PA
	fand ow		10a. State	10b. County		10c. City, To	vn or Lo	cation						10d. Inside City Limits
	a-f sh ified	ctor	MD	Montgo	mery	Silver	Spi	ring						1 XYes 2 ☐ No
	or 28)ire	10e. Street and Nu	ımber				10f. Zip Code				10g. Citi	izen of What Co	untry?
	s 23a	ral		eneagles		· 2A	10.1	20906		higin? (Cno	oif. Vac or No	US	A 14. Race - Amer	ican Indian
	ter de iner n	Funeral Director	 Marital Status Never Mar 	ried 2□ Married	12. Was Decedent I Armed Forces? 1 ∏ Yes 2 □ N		13.	Was Decedent of H If Yes, specify Cub			Rican, etc.)		Black, White	
2	be filed within 72 hours after death with the Maryland tha Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 🔀 Widowed		1 Yes 2 □ N If Yes, Give Year or Dates:	1946		1□Yes 2∏ No	Specif	y:			Specify: Whi	te
2	72 ho 'natur dical	Completed	(Spe	15. Decedent's E	ducation rade completed)	16	(Give	dent's Usual Occup kind of work done	during me	ost of worki	ng i	16b. K	ind of Business/I	Industry
7	within ene. than '	dm	Elementary/Sec		College (1-4or 5			DO NOT use retire trician	a)			No.	anufactu	min.
7	filed Hygi other ent, tt	Be Co		(First, Middle, Las	t)		1100	LITCIAN	18. Mot	her's Name	(First, Middle,			11 1112
<u> </u>	uld be Mental rked o	To B	Clifford	d C. Coms	tock			-	Кe	ba E.	Leight	У		
<u> </u>	2 sho and { ls ma			lame/Relationship		19		ng Address (Street				er, City o	or Town, State, Z	(ip Code)
≥ ນົ	1 and Health Pm 27 ther th		Leland I	E. Comsto	ck	20h Place		249 Sweet sition (Name of	Mea		n. Lay		sville,	MD 20882 Town State
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inmoortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2		Removal from State	cemet	ery, crei	natory or other pla	· i				,	
	nit. P artme ortani Injun		-	uneral Service Lice		Hetro	22	Ltan Cren 2. Name and Addre	ss of Fac	$\frac{y}{\text{lity}}$ R.	Cunnin	ALC 12 hai	exandria m Funera	ı, VA ıl Home
ă	permi Depar Impor any Ir		Mue	all a	alle			2429 Wilm						
	200		230. Fart1. Enter shock or he	the disease, or cor art failure. List onl	mplications that caused y one cause on each lir	I the death. Do	not ent	er the mode of dyi	ng, such a	as cardiac o	or respiratory ar	rrest,		Approximate Interval Between Qnset and Death
F	Physician		immediate Cause disease or conditi resulting in death)	on	Cardi	onyo	m	ally						year.
	/Medical Examiner		resulting in death		Due to (or as	a consequence	effi:	0)	rea.					Year
	The Conf	er	Sequentially list of	onditions,	b. Due to (or as	a consequence	e of):	my aus	· a	J.			*	5
3	cuted nd ransit	Examin	Sequentially list on any, reading to it cause. Enter Und Cause (Disease of that initiated events)	r injury	c									
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000	rificate be executed g physician and as the burial-transit	edical			d									
X 20	certifi nding use as		IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome								23d. Date of deli	ivery
ă	death e attei id for u	sician/N	in the past 12	2 months?	1□Live birth 4□Pregnant at			∃Ectopic pregnanc ∃ Other (specify) _	У				Month	Day Year
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NI P	an: T tificat tor, pa	a l	25. Was case refe	erred to medical					26. Pla	ce of Death	1 Yes 1 (Check only o	21 No	1∐Yes	2 No
>	nysici	To B	examiner? 1 ☐ Yes 2	g No	Hospital: 1 ☐ Inpatie	ent 2 ER/C	Outpatier	nt 3 □ DOA Oth	ner: 4🗷	Nursing Ho	me 5 Resid	dence	6 □Other (Spec	cify)
5	Ing P		27. Manner of Dea	5 Pending	28a. Date of Inju (Month, Da		. Time o Injury	Wo	rk?		28d. Describe l	how inju	ry occurred	
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2	al or A after I Dire d in b	Certification:	4 🗌 Homicide	getermine	building, et	c. (Specify)					City or Tov	vn, State	9)	
	To the Hospital or Attending Physician: The law within 24 buvus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s		29a. Certifier (Check only		Physician: To the best aminer: On the basis o									
	the H	Medical	one) 29b. Signature an		and manner st	ated.								
	5 <u>4 €</u> §		Run Run	M	-ms			D2	395	8		5	1,210	7
	•		30. Name and add	dress of person wh	o completed cause of d	leath (Item 23a) (Type,	Print)	, i	D) /	C/1 =	-/-	, /	n, Day, Year) 7 D 20906
	20		BUA I.S	Eldmer	m.D. 330	5 N-L	en	ure Wor	/d 2	S/M-	المحالاد	39	ringin	100
	Sta	ite	31. Date filed (Mo	onth, Day, Year)	32. Registr	ar's Signature	100	4						

DHMH 17 Rev 1/2001

Registrar

MAY 1 8 2007

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** DUNNOCK HENRIETTA /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Sina BALTIMORE 1405 al paltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 12 1922 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 XF Days Hours Min Director 85 212-20-3879 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County fshow is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mertal Hygione. Hem 23a or 28a-f show tems 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 2422 BILBURY by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give 4-Year or Dates: Specify: 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry tenrietla (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GENERAL SERVICES ADM CUSTODIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALLACE CLAUDE ဥ MADIE CARR 19b. Mailing Addrag finding Number or Rural Route Number, City or Town, State, Zip Code)
7401—AUMONT ROAD., BALTO., MD 21244 19a. Informant's Name/Relationship (Type. Print) ROWENA RICE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If it any injury or c 1 N Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 5/23/07
Thy JAMES A. MORTON & SONS F.H., INC 4 Donation 5 Dother (Specify) BALTIMORE NATIONAL 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility 1701 LAURENS STREET, BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) severe **Physician** ische mic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as t IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy j in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown cate has been si , page 2 should t 1 ☐ Yes Completed autopsy performed certificate Division or Vital 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#19b perFH, G867-5/18/07 WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Year

2007

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

USA

10:15

Birthplace (State or Foreign Country)

NO

10d. Inside City Limits

Approximate Interval Between Onset and Death

years

Year

1 ☐ Yes X☐ No

DHMH 17 Rev 1/2001

01

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Xiono

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

n

D,

Ph

32. Registrar's Signature

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** avidson 16 2007 argare /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner toco 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 X F Hours 8 -12-10000 2 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21015 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 2 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) non homemake 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) ဂ္ 19a. Informant's Name/Relationship (Type. Print) xottsdale MO21015 lackli M 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation
4 ☐ Donation 5 ☐ Other (5 Date 20c. Location - City or Town, State 3 Removal from State Evans Funcial Chapel-Bildic 3 rovest Hill 5 ☐ Other (Specify) port A, Forest HillMDZILL 21. Signature of Funeral Service Lipenses pel-Cremation Services-Bel Arr Evans Funeral Cha 23a. Part 1. Enter the disease, or complications that caused the chath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer Non-**Physician** 50 year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the ! IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 21 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 🔁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10

State Registrar PHILIPNIVATPUNIL 31. Date filed (Month, Day, Year) MAY 1 8 2007

N 6025, ATWOOD ROAD, SUITE 200, DALTIMORE, MD 21014

Physiciz

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0058475

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Dorothy Mae Sharpe Davis **Physician** 2:30PM Mare 2007 llo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Lanham Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 72 Yrs. 5. Social Security Number 6 Sex March 13, 1935 **Funeral** Months Days 223-44-6473 1 M 2 XF VA Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State ns 23a or 28a-f show must be notified at Portsmouth VA Portsmouth 1XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23704 USA 50 Riverview Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Specify: Black 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 N Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Home Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norfleet Lelia Sharpe Leslie 19a. Informant's Name/Relationship (Type. Print)
Cheryl Edwards / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Riverview Avenue, Portsmouth, VA 23704 Baltimore, May 22, 2007 Character Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Memorial
Gardens 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State Chesapeake, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee buta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** /Medical Due to (or as a consequence of): Examiner SPIRATION Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and MYOTROPHIC Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 EPTICEM Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe death? 1 ☐ Yes 2 ☐ No 2000 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) 1 Avatural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Lanham, MD. 20706 8118 GOOD LUCIL 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 18 2007 Registrar

a

07-03684 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day May 13, 2007 Medical Examiner 2325 hrs James Drake 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mercy Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or **Funeral** 215-94-0200 Months Days Hours Director 1/19/63 MD Country) 1 X M 2 F 44 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/ABaltimore City 1 X Yes 2 No with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 West Conway, 606 21201 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, death v If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Armed Forces' White, etc. Married Yes 2 X No White f Yes, Give Year 1 Yes 2 X No specify: hours after Widowed Divorced Specify. ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 P Department of Health and Mernal Hygiene. Important: If item 27 is marked other than "" injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Window Installer 11 0 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Basil Drake Nancy I. Cowsill æ 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy I. Drake / Mother 600 Light St. # 519, Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State BayView Crematory Burial 2 X Cremation 3 Removal from State 5/15/2007 Baltimore MD Donation 5 Other Specify 21 Signature of Funeral Service License 22. Name and Address of Facility Victor P. Doda Charles L. Stevens Funeral Home, Inc 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate In erval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Congestive Heart Failure Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhosinian and completely filled in by the funeral director mann attending the funeral director. Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **Diabetes Mellitus** Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V N Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one æ examiner? Hospital: Other-DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifite 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 14, 2007 ss of person who completed cause of death (Item 23a) 3 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year) State

32 Registrar's Signature

ORIGINAL

DHML II Rev 17:001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	aryland		artment o				200		6140
			Decedent's Name (First, Middle,	Last)			imouto	or Doa		2. Date of Dea	Reg. No U U	3. T	ime of Death
	Physici /Medi		NICHOLE I	UFFETT	-					Month		ear 07 /	341 M
	Examir		4a. Fecility Name (If not institution,)		4b. City, To	wn, or Locati	on of Death		4c. County of	Death	
			UNIVERSITY OF MAN		CALCO	ATER	BI		rone		N/A	A	
ı	Funeral Director		5. Sociaf Security Number 213 04 8079	5. Sex 7. Ag 1	ge (In yrs. Ias 23	t birthday) Yrs.	Months D	ear If Un ays Hou	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day August	^п , _{Year)} 9. 18,1983 М	Country)	State or Foreign
	puq .		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	estion						
	lanyla sho	ច		Arundel		nthic							ide City Limits Yes 21 No
	the N	Director	10e. Street and Number	Riunder	1 111	101110	10f. Zip Co	ode			10g. Citizen of Wha		
	th with 23a or	ai Di	301 Double Ea	gle Drive				21090			U.S.A	,	
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 ie marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Markical Examinating is notified at	by Funeral	11. Marital Status 1 🕱 Never Married 2 🗍 Marrie 3 🗍 Widowed 4 🗍 Divorced	12. Was Decedent Armed Forces d 1 Yes 2 1 If Yes, Give Year or Dates:	?	'	Was Deceden f Yes, specify 1 ☐ Yes 2 [x]	Cuban, Mex	ican, Puerto F	city Yes or No- Rican, etc.)		American Ind White, etc. White	an,
5	72 h natu	etec	15. Decedent's (Specify only highest	Education grade completed)		(Give	lent's Usual C kind of work of	one durina r	ost of workin	g	16b. Kind of Busin	ess/Industry	
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. r ie marked other then " raumatic event, the Mas	Completed	Elementary/Secondary (0-12)	Colfege (1-4or	5+)	Sale	DO NOT use r	etired)			Automoti	ve	
pu	al Hy al Hy d other	Bec	17. Father's Name (First, Middle, La					18. M	other's Name	(First, Middle,	Maiden Sumame)		
yla	ould to Ment mrke arke	5		iel W. Duff	ett				Debora	h S. La	amb		
	and 2 sh salth and n 27 ie m	18	19a. Informant's Name/Relationshi Deborah Duffe				g Address (Si ouble				r, City or Town, Sta nicum, Ma		21090
Baltimore,	8 2 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cem	etery, cren	sition (Name of natory or other 1 Ceme	r place)	5/7/2		20c. Location - Cit Baltimor		
Balt	permit. Pa Departmen Important: eny injury once.		21. Signatur, of Funer of Service Li	censee	,	4C	Name and A	ddress of Fa	clity Gon lighway	ce Fune Balti	eral Serv Lmore, Ma	ice, P ryland	.A. 21225
			23a. Part 1. Enter the disease, or conshock, or heart failure. List of	omplications that cause	d the death.	Do not ent	er the mode of	dying, such	as cardiac or	respiratory arr	est,		ximate al Between
	Physician /Medical		Immediate Cause (Finaf disease or condition resulting in death)	a		EBR	AL						and Death
	Examiner	ēľ	Sequentially list conditions,	b. — Due to (or as									
	uted 1 ansit	mine	any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	220 10 (31 83	2 001.004431	103 01).							
60,	icate be executed physicien and s the burial-transit	i Examin	resulting in death) Last	c. Due to (or as	a consequen	ice of):							
68760,		dicai		d.									
.O. Box	at the death certifi by the attending (tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3 🗆	Ectopic pregn				23d. Date of Month	f delivery Day	Year
Φ.	es thi	۾	Part ff. Other significant condition	s contributing to death b	out not resulting	ng in the ur	iderlying caus	e given in Pa	rt I.		bacco use contribu		
Ö	w requir been si should	eted								1 🗆 Ye	es 200 No 3	Probably	4 Unknown
l Records,	The ate ha	Completed								24a. Was a autops perform	ry prior med? deat	to completion	
/ita	Physician: Tripis certificatal director, p	Be	25. Was case referred to medical examiner?						ace of Death	Check only on	/		
of	Physi this o	6	1 ☐ Yes 25 No		ent 2□ER						ence 6 Other (Specify)	
ion	fing After Tune	ation:	27. Manner of Death 1	28a. Date of Inju (Month, Da tion	y Year) 28	b. Time of fnjury		Injury at Work? 1 ☐ Yes 2		3d. Describe ho	ow injury occurred		
Division of Vital	5 #	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad 286. Place of Inj	ury - At home c. (Specify)	, farm, stre	eet, factory, of	fice	28	Bf. Location (St. City or Town	reet and Number on, State)	r Rural Route	Number,
	To the Hospital within 24 hours e No the Funeral I completely filled	ledical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examination	dge, death and/or inv	occurred at the	ne time, date my opinion, d	and place, ar leath occurred	nd due to the ca	ause(s) and manne ate and place, and	r as stated. due to the ca	use(s)
	within 2 comple	ž	29b. Signature and title of certifier				29c. Lie	cense numbe	ər	2	9d. Date signed (M	fonth, Day, Ye	ar)
	7		Ronn	my			1 P2	1141		4	5/2/20	07	
6)		30. Name and address of pers	o completed cause	leath (Item 23	la) (Type, I	Print)	STREET	Balli	mars.	MD 2	1701	
Ĭ	Sta Registr	16	31. Date filed (Month, Day, Year)	o completed cause of	ar's Signature	Ina	Les .		1911		100		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland 1007 1800 of the Health and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 13 2007 Physician 7:52 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Baltimore County Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 55 July 10 1951 Alabama 219 58 4544 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ages 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.

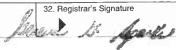
It of Health and Mental Hygiene.

It filem 27 is marked outher than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 1012 Susquehanna Avenue by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State of Maryland Dept. of Elementary/Secondary (0-12) College (1-4or 5+) Human Resources 12 Contract Compliance Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Connelley Jackson Julian Edwards ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1012 Susquehanna Avenue Baltimore, Maryland 21220 M. Ann Edwards (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. May 17 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** coronary resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequency ut): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed 24a. Was an autopsy performed? 1□ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Startesidence 6 Other (Specify) 1 XYes 2 No 2 ER/Outpatient 3 DOA ျှ 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A pletely filled in by the fi 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Physician) ဂ္ 5-14-2007 30. Name and address of person who completed cause of death (Item 23a) (Type Print) RD. Suite 300, BATIMONE MD 21237 Kevin Schendel

State Registrar 31. Date filed (Month, Day, Year)
MAY 1 8 2007



EDWARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Albin trederick na 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May, 31, Medical versita ara Cand 7. Age (In yrs. last birthday) If Under 1 Year 64 Vrs Months Days Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** M ZDF 214-42-1975 1942 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hygiene, matural, or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "instural;" or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at any Injury or other traumatte event, the Medical Examiner must be notified at MD N/A Baltimore City Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 UNited States 1522 Latrobe Park Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Salesmen Sales 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Freferick A. Eklund, Jr. Margaret E. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 Latrobe Park Terrace, Baltimore MD 21230 Patsy J. Eklund / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 18, 2007 Baltimore MD Cedar Hill Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician Hemore hay /Medical Due to (or as a consequence of) **Examiner** Graft Hortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Dav Year 5 Other (specify) ☐Yes 2☐No should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO 24a. Was an autopsy performed? 1 res 2 □ N certificate has 2 No To the Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No ၉ 1 Impatient 2 □ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 ☑ Natural Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 ame and address of person who completed cause of death (Item 23a) (Type, Print) Street Bo 22 32 Registrar's Signature onth, Day, Year) State 8 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#20a, perFH, G867, 5/18/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MonthMAY Day7 12:00PM **Physician** <u>Herbert R. Frantz, Jr.</u> /Medical 4b. City, Town, or Location of Death 4c. County & Beath imore 4a. Facility Name (If not institution, give street and number) Center Examiner If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**X** M 2□ F Director 09/16/1921 85 Maryland 215–14–8038 death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Kingsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11703 Silver Spruce Terrace 21087 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Estimator Construction is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Pansey Ehlers Herbert R. Frantz, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health at Important: If item 27 is any injury or other trau (wife) <u>Jean M. Frantz</u> <u> 11703 Silver Spruce Terrace -</u> _Kingsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State - 1X Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/18/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland assahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Physician /Medical CORONARY ARTERY DISEASE Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed Due to (or as a consequence of) Physician/Medical attending plant for use as as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 2 No ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 □Unknown RENAL FAILURE 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy nerform certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1X Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) MAY 1 8 200

TIMOTHY LOW.

29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D24034

TOWSON. MARYLAND

29d. Date signed (Mooth, Day, Year)

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Vera Ruth Filby 15 Ρ 2007 4:30 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8944 Madison Street Savage Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 200 86 24, 1921 New Jersey Director 136-18-6136 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the M. dt.al Examiner must be notified at 1 Yes 2 No Director MD Savage Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 8944 Madison Street 20763-0913 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 😾 No <u>ک</u> Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crypto Analyst US Government permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Herbert A. Weakliem Anne Lemercier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert A. Weakliem/Brother 132 King George Road, Pennington, NJ Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 5/17/2007 Odenton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enterithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Thrombosis Approximate Interval Between Onset and Death **Physician** Minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) 1☐Yes 2∏No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed certificate 1☐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 1 ☐ Yes 2 ☐ No

the Hospital or Attending Physician: The law requires that the death certificate be execu P.O. Division or Vital Records. After death. after death Director:

Maryland 21215-0036

Baltimore.

Certification: To filled in by

2 Accident

5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a. Certifier

3 ☐ Suicide

4 ☐ Homicide

31. Date filed (Month, Day, Year)

🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

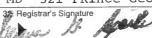
ense number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

321 PRince George Street, Laurel, MD MD 20707 William A. Warren,

State Registrar

Medical



e Funeral

To the Hosp within 24 ho To the Functional

DHMH 17 Rev 1/2001

Registrar

8 2007

07-03700 Gary Finkle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ary Finkle		State of Maryland / 1- For State Amend #5 Per Inf G	Depai 86 7 e≸	rtment of F	leaith and Bath	ı wenta	ат нудк		g. No. 20	07 1614
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Gary A. Fir	ıkle				2. D M	ate of Death Ionth ay 14, 20)	3. Time of Death 1050 hrs
()		4a. Facility Name (if not institution, give street and number) 6502 Liberty Road			City, Town, or Gwynn Oak		Death	ay 14, 20	4c. County of D	
Funeral			e (In yrs. Ia		If Under 1 Year	If Under	_	Date of Birth	n(MM/DD/YYYY) 9	. Birthplace (State or
Director		210-32-1473 219-34-1473 1XM 2F	69	Yrs.	Months Days	Hours	Min. O	3/02/:	1938	countryPenna.
w any		10a. State 10b. County		Town or Location						10d. Inside City Limits
Maryland 28a-f show 1 at once.	Director	Maryland Baltimore 10e. Street and Number	Ва	ltimore	0f. Zip Code			10	g. Citizen of What	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	_	6502 Liberty Road			21207				U.S.A	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-1 she tranmatic event, the Medical Examiner must be notified at once	Funera	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 X Yes 2 3 Widowed 4 Divorced If Yes, Give Yeer		If Yes,	Decedent of His specify Cuban es 2 X No	, Mexican, I			14. Race - A White, et	
iours aft natural" xamine	ed by	15. Decedent's Education (Specify only highest grade com	ipleted)	16a. Decedent's		ion (Give ki		done	16b. Kind of Busine	
1215-0036 Id be filed within 72 h fental Hygiene, narked other than "n event, the Medical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5	5+)	•	k Drive	er			Truckin	ıg
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) Chalmer Finkle	е				Name (Firs Julia		laiden Surname)	
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental. Important: If item 27 is marked injury or other traumatic event,	ပ	19a. Informant's Name/Relationship (Type, Print) Marcia Brandenburg / Aunt			ddress (Stree				ber, City or Town, S Maryland	
nore, MD 2 ages I and 2 shoul nt of Health and M tt: If item 27 is m		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta		Place of Disposition rematory or other		netery,	Dat		20c. Location - Cit	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ayview C	remator			/2007		re, Maryland
Balt permit. Departi Import	Į,	11.12		400	1 Ritch	ie Hi	ghway	Balt	timore, M	ice, P.A. aryland 21225
Physician /Medical	£ 17	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive At					rdiac or resp	oiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a conse			4000.4. 270					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):						
cu ted nd transit	l Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a conse	equence of)):						
O, e be exec sician a	Medical	UNPENDED AMENDED								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcon 1 Live birth 4 Pregnant at 9 Unknown		2 Fetal	death 3 (Ectopic	pregnancy		23d. Date of del Month	ivery Day Year
i, P.O. I rres that the signed by t	by	Part II. Other significant conditions contributing to death Diabetes Mellitus	but not re	sulting in the und	erlying cause g	iven in Par	t I.	process	2 No 3	te to the cause of death? Probably 4 Unknown
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tal Reco ician: The law certificate has	Be Co	25. Was case referred to medical examiner?					Check only o	1 Yes 2	1 V	Yes 2 No
n of Vit hing Physic After this of funeral dire	ပ္	examiner / 1 Vyes 2 No Hospital: 1 Inpatie 27. Manner of Death 28a. Date of Inju (Month, Day, Y	Land	ER/Outpatient 3		Other ₄	Nursing Ho		Residence 6 🗸 C	Other: Scene
Sion (Attending death. ctor: Af	ertification:	2 Accident Investigation				es 2 1				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certifi	4 Homicide Could not be determined (Specify)	jury - At ho	me, farm, street,	actory, office b	uilding, etc.		or Town, St		or Rural Route Number, City
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of ex								
\	Ž	29b. Signature and title of certifier			29c. Licenso				29d. Date signed May 15, 2007	(Month, Day, Year)
51 4		30. Name and address of person who completed cause of d. Jack Titus MD. Deputy Chief Medical E.	,		Street, Balt	imore, N	1D 21201			
S	tate	31. Date filed (Month, Day Year) 32. Registrar			1					

DHMH 17 Rev 1/2001 OCME 2006

		1 - For State Registrar	State of Marylan		artmer			d Me		iene	007	16147
	ш	Decedent's Name (First, Middle, Last)					2.	Date of Deat Month	th Dey	Year	3. Time of Death
Physic		William Paul Gor	rdon						May	16,	2007	5:00 P M
/Medi Examir		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location of D	eath		4c. C	County of Dea	th
		Hart Heritage					reet				Harf	ord
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under 24 I	Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Bir	thplace (State or Foreign ountry)
Director		162-12-1785	88	Yrs.				M	ar. 21	, 19	19 P	<u>ennsylvania</u>
pur *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation							10d. Inside City Limits
Aaryli I sho	ō		. Force	Dol 74	~							1 ☐ Yes 2√2 No
158.1	Director	Maryland Harfo	ora	Bel Ai		p Code			1	0g. Citize	en of What C	ountry?
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leath	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Dece		spanic Origin n, Mexican, Pi	? (Specif	y Yes or No-		4. Race - Am	
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Sours a	٥	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW	II	1 🗌 Yes	2L X N0	Specify:				Specify: W	hite
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be fi	Be	17. Father's Name (First, Middle, Last)										
should and Men marke	2	Jacob R. Gordon 19a. Informant's Name/Relationship (T)		10h Maili	ina Addres	s /Street s	Amand and Number o		nmn) F			Zin Code)
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1 and 1 and 27 em 27 other tr		Cheryl G. Monk /	20b. F				d_Drive	e, B	er Air	20c. Loc	ation - City or	Town, State
Pages nent of int: If its		1 Burial 2 Cremation 3 1	Removal from State	cemetery, cre untain				5-19	-07	Jop	pa, Ma	rvland
		21. Signature of Furreral Service Ligens					s of Facility uneral				Pa, 12.	
permit. Departr Importa		NI Shalle IV	Man and Hole	to	MCCOr 50 t	nas f J Br	uneraı <u>oadway</u>	HOM	e, P.A 1 Air	Mar	vland	21014
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal	th. So not en	iter the mo	de of dyin	g, such as car	diac or r	espiratory arr	est,	7 2002.00	Approximate Interval Between
Dhysisian		Immediate Cause (Final	one cause on each line.	15 5	TAS	c 7	Zernan	+S	3			Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec		,,,,	Ç.a.			*			7213
Examiner												
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ath co	lan	23b. Was decedent pregnant in the past 12 mopths?	23c. If yes, outcome of pregnant 1 Live birth 2 Fets	ol death 3	□Ectopic (2.	3d. Date of de Month	Dey Year
the g	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at time of c 9□ Unknown	ieatri 5 t	□ Otner (s	pacity)						
The law requires that the death certifica The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it		Part II. Other significant conditions co	intributing to death but not res	sulting in the u	underlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute t	to the cause of death?
requires (d by								1 🗆 Y	es 2	No 3 □ P	Probably Unknown
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in: Ti ificate or, pa	ပိ	25. Was case reterred to medical					26 Place of	Death //	1□ Yes Check only or	2 No	1 🗆 10	Assisted
Physician: The Physician: The Ithis certificate harral director, page	0	evaminer?	Hospital: 1 Inpatient 2] ER/Outpatie	ent 3 🗆 🗅	OA Oth					Other (Spe	ecity) CARE
	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injun Worl			d. Describe h	-		
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Atts acto by th	ific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	treet, facto	ry, office		281	f. Location (S City or Tow		Number or F	Rural Route Number,
s afte	Certification											
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier Certifying Phy (Check only 2 Medical Exam	ysicien: To the best of my knowiner: On the basis of examina	owledge, dea	th occurre	d at the tim	ne, date and p	olace, and	d due to the c at the time, d	ause(s) a late and	and manner a place, and du	is stated. le to the cause(s)
the H iin 24 the F	ledi	one)	and manner stated.			e. License						oth, Day, Year)
To To con	Σ	29b. Signature and title of certifier	11					i i			-	
n a		1/2//	17 /11				9889				•	,2007
3		30. Name and address of person who control of the c	completed cause of death (Item	m 23a) (Туре	, Print) アカゴ	انه	Bel .	1.1	MA	210	14	
	ate	31. Date filed (Month, Paya Year)	200732. Registrar's Sign	ature //	Lugar	M. D	, ,		1740			
SI Regist		31. Date filed (Month, Pay Year) 8	2001	And the same	A STATE OF THE PARTY OF THE PAR	AR VIII						

			For State Registrar	State of Mar		/ Depa		t of H	ealth a		ental Hyg	giene	007	16148
	Physicia		1. Decedent's Name (First, Middle, Last)	enco						1	2. Date of Dea Month		Year 2007	3. Time of Death 9)10 Am
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)					Location o		1	4c. Co	ounty of Death	re
Ī	Funeral Director		5. Social Security Number 6. Sex		In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min	B. Date of Birt (Month, Day Sept. 1	, Year) .5,192	9. Birth Coul. Ken	place (State or Foreign ntry) tucky
puelvie	show	_	Usual Residence of Decedent 10a. State 10b. County Marvland Baltime	1		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🖫 No
the the	or 28a-f)irecto	10e. Street and Number			LOIISV	10f. Zip		200			-	n of What Cou	ntry?
die ob	ms 23a	neral [6528 Redgate Cir	2. Was Decedent Ev Armed Forces?	er in U.S.	. 13. V	Was Deced	212 dent of Hi		gin? (Spec	effy Yes or No-		S.A. Race - Ameri Black, White,	
IIIG Z I Z I D-0030	permit. Fages I and a should be liad within 72 flours and began with any manyan permit. Pages I and a should be liad within the light statement of Health and Mantal Hygione. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant, Itie Madical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			1 🗆 Yes		Specify:	i, i doite i	and any otter,	Sį	pecify: Whi	te
0-C17	e. an "natu Medical	npletec	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+))	life. L	kind of wo DO NOT u	rk done d se retired,	luring mos)	t of workin	g		of Business/Ir	ndustry
ומ ליו	al Hygier d other th	Be Cor	12th 17. Father's Name (First, Middle, Last)				emp.	Loyed	18. Mothe		(First, Middle,	Maiden Su	aurant _(mame)	
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HOLE	ages in an of Hite. If item yor off		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 🖾 Other (Specify)	emoval from State	cer	ice of Dispo metery, cren raine	natory or c	ther place					•	Maryland
Daltimor	Departme Importan any injur		21. Signature of Funeral Service License	ne -	1	22	2. Name ar	nd Addres	s of Facili	ty Gon	ce Fun	era1	Service	
	busisian		23a. Pont. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final	cations that caused to be cause on each line	he death.	Do not ent	er the mod	le of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a	conseque	ence of):	9		TVCC			· <u>-</u>		2 Mennie
	pe eq	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a	conseque	ence of):								
/۵۵	eath certilicate be executed attending physician and for use as the burial-transit	cal Exan	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):								
	armicate ing phys e as the		IE EEMALE:		6									
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ds, P.	w requires that the de been signed by the s should be detached	b	Part II. Other significant conditions con	A	t not resul	lting in the u	inderlying (ause givi	en in Part I	l. 	23e. Did t			the cause of death?
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		Be	25. Was case referred to medical examiner?	lospital:				Oth			(Check only	one)		
on of	al d	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	,	28b. Time o Injury		28c. Injur	4 🗆 14		ne 5 M Resi		Other (Spec	ity)
Division	or Attending I after death. Director: After I in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hor . (Specify)	me, larm, sti	reet, lactor	y, office		2	28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Exemination (Check only one)	sicien: To the best o ner: On the basis of and manner stat	examinati	vledge, deat ion and/or in	th occurred nvestigation	I at the tin	ne, date a pinion, de	nd place, a ath occurre	and due to the ad at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier	Pol	10		-		e number	-//		29d. Date	signed (Month	n, Day, Year)
9	9		30. Name and address of person who co	ompleted cause of de	ath (Item	23a) (Type,				4		1/1	0 21	239
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra			1010	/\\ \C		716-1	TORC	_ /000	<i>y</i> & <i>i</i>	να /

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year James Givens 7:10 a.m.M May 10, 2007 /Medical 4b. City, Town, or Location of Death Ellicott City 4c. County of Death Howard 4a. Facility Name (If not institution, give street and number) **Examiner** 5029 Orchard Dr. 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day. 9. Birthplace (State or Foreign **Funeral** 1 M 2□F Months Days Min. 216.28.1558 8 Yrs. February 13, 1929 Director Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Mannent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23a or 28a-f shury or other traumatic event, the Medical Examiner must be notified. Director Maryland Howard Ellicott City 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 5029 Orchard Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aluminum manufacturing machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Givens Eva Seal ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauonce. 5029 Orchard Drive Ellicott City, Maryland 21043 Ms. Lois E. Givens Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 SCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/15/07 Baltimore, MD **Bayview Crematory** 21. Signature of Funeral Service Lipense MO1293 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a p sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as Vonsequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No cate has b 24a. Was an autopsy certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ို Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 | Pending investigation 1 🗌 Yes after death I Director: / d in by the f 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

10

State Registrar

29b. Signature and Alle of certifier

31. Date filed (Month, Day, Year)

MAY 1 8 2007

30. Name and address of p

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on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Şignature

29c. License number

4113

29d. Date signed (Month, Day, Year)

2002

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			1 - For State Registrar	State of M	larylan			nt of H te of L		and Me		ene g. No.	07	16150
	*		1. Decedent's Name (First, Middle, Las	st)							2. Date of Death Month		Year	3. Time of Death
	Physicia /Medic		CATHARINE FAITH	HEISS							Month MAY		00 ^{Year}	8:17A ™
	Examin		4a. Facility Name (If not institution, giv. NATIONAL LUTHER)	AN HOME			RC	CKVI					FGOME	RY
	Funeral Director		5. Social Security Number 212=05=1043 6. S	7. A □ M 2 X 2XF	ge (In yrs. 94	last birthday) Yrs.	Months Months	Days	If Under Hours	Min,	8. Date of Birth (Month, Day, JULY 2,	1912	9. Birti Coi Ma	nplace (State or Foreign untry) ryland
•	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	ith the Marylan or 28a-f show	៦	Maryland Montgome	erv	100.00		(vil]	.e						1 ☐ Yes 2 🛣 No
	28a-1	Directo	10e. Street and Number	,- ,				p Code			10	Og. Citizen of	What Co	untry?
	3a or	Ö	9701 Veirs Drive					20	0850			USA		
	death	Funeral	11. Marital Status	12. Was Deceden Armed Forces		S. 13.	Was Deci	edent of Hi	spanic Ori n, Mexicar	gin? (Spe	cify Yes or No- Rican, etc.)		ice - Amei ack, White	rican Indian, e, etc.
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2	should be filed within 72 hours after death with the Maryland and Mantle Hygiene. In the Hygiene snarked other then "natural", or items 23a or 28a-f show marked other then "natural", or items 23a or 28a-f show umatic event, the Houldel Exercities in the notified at	Be	17. Father's Name (First, Middle, Last Milton Kraft)							(First, Middle, A		ıme)	
y	ould b Ment warke	၉		T 0000		10h Maili	a a A dalaa	Ctroot			ra Pfist <i>Route Number</i> ,		n State 7	in Code)
Mai	d 2 sh th and 7 is n treun		19a. Informant's Name/Relationship (Wilda M. Heiss ()	**							eenbelt,			
ני	Heal Heal tem 2		20a. Method of Disposition		1 -	Place of Dispo	sition (N.	ame of				20c. Location		
2	Pages ent of nt: if i		XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		e i	rkwood	Ceme	etery	5	-19-		Baltimo		
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Marial Hygiens. Department of Health and Marial Hygiens. Instured, or items 23a or 28e-f show important: it item 27 is marked other then "natured, or items 23a or 28e-f show eny injury or other treumatic event, tra Modical Exerphagn count for notified at once.		21. Signatule of Funeral Service Lice	nsee							ssahn Fi			
ם	82 = 8	100	23a. Part1. Enter the disease, or com	Ssch							ltimore		2;230	Approximate
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leco.	e law req has beer je 2 shou	ompleted									24a. Was a autops	ned?	death?	utopsy findings available completion of cause of
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>	ysicie is cert direct	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	atient 2] ER/Outpatie	nt 3 🗆 I	OOA Oth	00		ne 5 Reside		ther (Spe	cify)
Sion of	ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		njury Da <i>y Year)</i>	28b. Time o Injury	of M	28c. Injur Wor 1 🗍	yat k? Yes 2.□		28d. Describe ho	ow injury occ	urred	
DIVIS	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Att completely filled in by the fun	Certification:	3 Suicide 6 Could not to determined	28e. Place of I	Injury - At h etc. (Speci	ome, farm, st	reet, fact	ory, office			28f. Location (Si City or Town	reet and Nur n, State)	mber or Ri	ural Route Number,
	Hospite 24 hours Funere etely fille	Medicai C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the beaminer: On the basis and manner	of examina	owledge, deal ation and/or in	th occurrenvestigati	ed at the tir	me, date a opinion, de	nd place, a ath occurre	and due to the co	ause(s) and r ate and place	manner as e, and due	s stated. e to the cause(s)
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			30. Name and address of person who									208	2 (7)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 8:40 A. Myrtle Isabelle Harman May 13 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Heritage Center Baltimore County Dudalk If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 M 2 XF 85 1921 Maryland Nov. 6 217-14-6000 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Baltimore Baltimore County Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21236 United States 7402 Virginia Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item ∏Yes 2∑No fYes, Give ∕ear or Dates: 1 Never Married 2 Married 1 □ Yes 2 🖔 No specify: White altimore, Maryland 21215-0036 Specify Completed by 3 XWidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grover Leese Lula E. Richard မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7402 Virginia Avenue, Baltimore, Maryland 21236 Mrs. Nancy Ciotta (Daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ò Department of Important: If any Injury or once, Forest Hill, Maryland Evans Funeral Chapel May 17,2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr., P.A. Peaceful Alternatives Funera 2325 York Road, Timonium, Marshock, or heart failure. List only one cause on each line. 2325 York Road, Timonium, Maryland 21093 Immediate Cause (Final disease or condition resulting in death) **Physician** ONGESTIVE /Medical Due to (or as a consequence of): 02711 Examiner Esquerdiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-trail Due to (or as a consequence of): Box 68760, attending physician Physician/Medical The law requires that the death certificate be for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent premant 3 Ectopic pregnancy Month in the past 12 menths? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Miknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has autopsy perform 2 No 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital within 24 hours a

To the Funeral I

completely filled 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certifier

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

		1 - For State Registrar	State of Maryla		epartment of F Dertificate of			iene2 () () 7	16152
		1. Decedent's Name (First, Middle, Li	ast)				2. Date of Deat Month	h Day Year	3. Time of Death
Physicia /Medica		Ma	rlene Joyo	e	Hoffman		May 10	, 2007	7:15P M
Examine		4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of Deat		4c. County of Death	1
CAUTITIO	•	Hebrew Home			Rockv	ille		Montgom	ery
Funeral		Social Security Number 6.	Sex 7. Age (In yrs	s. last birth	day) If Under 1 Year		8. Date of Birth	9. Birth	place (State or Foreign intry)
Funeral Director			1□M 2□XF 68	Yr	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 12	, 1938 Mi	chigan
and		10a. State 10b. County	10c. C	ity, Town o	or Location				10d. Inside City Limits
r 28a-f ehow	ō	MD Montgo	moru C.	11,,,,	r Spring				1 ☐ Yes 2 ➡No
1 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	by Funeral Director		mery 5.	TIVE					
the part	5	10e. Street and Number			10f. Zip Code			Og. Citizen of What Co	intry r
23a	ē	11105 Conti Pl	ace		2090			USA	
e E E	ine.	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	 Was Decedent of If Yes, specify Cub 	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
afte afte	Ę	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2√☐ No			0 4	
ours ours	9	3 ☐ Widowed 4 🔀 Divorced	Year or Dates:		X			WI WI	nite
72 h	tec	15. Decedent's E (Specify only highest g		16a. D	ecedent's Usual Occup	pation	deino	16b. Kind of Business/I	ndustry
ur s	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	- 'i	Give kind of work done ife. DO NOT use retire	d)	9		
filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Reme 23a or 28a-f ehow ent, the Medical Examiner must be notified at	0		4	Soc	cial Work	er		State of	Florida
oth oth	Be Completed	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	me (First, Middle, M	faiden Sumame)	
should be ind Mental in marked c umatic ev	은 일	Archie Crego				Blanc	he Klei	n	
mar mar	-	19a. Informant's Name/Relationship	(Type, Print)	19b. N	Mailing Address (Street	·		City or Town, State, Z	ip Code)
d2 s th ar 7 is treu		Todd Hoffman	- Son	- 1				o, FL 337	
1 end 1eelth em 27 ther tr		20a. Method of Disposition			isposition (Name of	Cleek L		20c. Location - City or	
Pages nent of I int: If It		1 ⊠Burial 2 □Cremation 3		cemetery,	crematory or other pla	1			
men men tant:		4 □Donation 5 □Other (Spec		mple	Emanuel	1 Cem 5/	13/07	Lakelan	d, FL
permit. Pages 1 end 2 should be filed within 72 hours Deperiment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "naturel; ery Injury or other treumatic event, Ita Madical Exa ance.		21. Signature of Funeral Service Lic	nsee		22. Name and Addre	ess of Facility Ge	entry Mo	rrison Fu	ın. Home
90F 9 9		pulle L	Sledle	_	1833 S.	FLorid	la Ave.	Lakeland,	FL 3380
		23a. P rt1. Enter the disease, or cor shock, it heart failure. List only	nplications that caused the dea	ath. Do no	t enter the mode of dyi	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between
Dhusisian		Immediate cause (Final			1				Onset and Death
Physician /Medical		disease or condition resulting in death)	a Metast			Cemc	er		·
Examiner			Due to (or as a conse	equence or,	•				
	_	Sequentially list conditions, if any, leading to immediate	b. Due to for as a conse	cupoma of					<u> </u>
p tis	in e	cause. Enter Underlying Cause (Disease or injury	D8010 (01 80 8 00100	qualica or,					
and tran	Examiner	that initiated events resulting in death) Last	C						
sicien and burial-transit		1030/ting in doutin) cast	Due to (or as a conse	equence or	:				
3 2 9	cal		d						
eath certifica attending ph for use as th	Physician/Med								
andin use	5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		3 TEmonia programa			23d. Date of deli	very
death a atte	<u> </u>	in the past 12 months?	4☐Pregnant at time of		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		Month	Day Year
by the a	Sy	9 □ Unknown	9□ Unknown						
that led b	<u>-</u>	Part II. Other significant conditions	contributing to death but not re	sulting in t	he underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
signed b	ар	parkinsons	disease.				1 □ Ye	s 2 No 3 Pro	bably 4 Whiknown
w require been si should I	Completed								
e law hes t	ā						24a. Was at autops	y prior to c	opsy findings available ompletion of cause of
The ate t	5						perform 1 ☐ Yes 2		2□ No
ysiclan: The la	Be	25. Was case referred to medical				26. Place of De	ath (Check only on	a)	
0 0 0		examiner?	Hospital:	□ ER/Outn	atient 3 DOA Ott	her: 4 Nursing I	Home 5 ☐ Reside	nce 6 Other (Spec	ifv)
ysi is c	0	1 Yes 2 No	1 Impatient 2						
Physi er this c	၉		28a. Date of Injury	28b. Tin	ne of 28c. Inju	ry at	28d. Describe ho	w injury occurred	
iding Physi th. : After this c	၉	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	1	ne of 28c. Inju-	ry at		w injury occurred	
utending Physideath. ctor: After this c y the funeral dire	၉	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	ne of 28c. Injury Wo	ry at	28d. Describe ho		
or Attending Physister death. Director: After this c in by the funeral dire	၉	1 Yes 2 No 27. Manner of Death 1 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tin Inju	ne of 28c. Injury Wo	ry at	28d. Describe ho	reet and Number or Ru	
oltal or Attanding Physiurs after death. rel Director: After this cilled in by the funeral dire	Certification; To	1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigate 3 Suicide 6 Could not 4 Homicide	28a. Date of Injury (Month, Day Year) on be d 28e. Place of Injury - At building, etc. (Spec	28b. Tin Inju home, farm	ne of 28c. Injury Wo 1 1	ryat rk?]Yes 2∏No	28f. Location (Str. City or Town	reet and Number or Ru , State)	ral Route Number,
Hospital or Attending Physis 4 hours after death. Funerel Director: After this c ely filled in by the funeral dire	Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury · At building, etc. (Spectary interest) Physician: To the best of my kruminer: On the basis of examiner.	28b. Tin	ne of 28c. Injury M 1 1 n, street, factory, office	ry at rk?] Yes 2 □ No	28d. Describe ho	reet and Number or Ru , State) use(s) and manner as	ral Route Number,
the Hospital or Attending Physinin 24 hours after death. The Funerel Director: After this copiesely filled in by the funeral dire	Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury At building, etc. (Spec	28b. Tin	ne of 28c. Injury M 1 n, street, factory, office death occurred at the ti or investigation, in my of	ry at rk? Yes 2 □ No No Yes and place No No	28f. Location (St. City or Town	reet and Number or Ru , State) .use(s) and manner as ate and place, and due	ral Route Number, stated. to the cause(s)
Ital or Attanding Phy Its after death. rel Director: After this ied in by the funeral d	၉	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury · At building, etc. (Spectary interest) Physician: To the best of my kruminer: On the basis of examiner.	28b. Tin	ne of 28c. Injury M 1 1 n, street, factory, office	ry at rk? Yes 2 \ No	28d. Describe had 28f. Location (Str. City or Town) e, and due to the caurred at the time, da	reet and Number or Ru , State) use(s) and manner as	ral Route Number, stated. to the cause(s)
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To the Hospital or Attending Physical Within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spectaminer: On the basis of examinand manner stated.	28b. Tin Inju home, farm nowledge, nation and/	ne of 28c. Injury Mo 1	ry at rk? Yes 2 \ No	28d. Describe had 28f. Location (St. City or Town) e, and due to the caurred at the time, day	reet and Number or Ru, State) suse(s) and manner as ate and place, and due ad. Date signed (Month)	ral Route Number, stated. to the cause(s) , Day, Year)

DHMH 17 Rev 1/2001

State Registrar

		For State Registrar	State of	Maryland		artment of rtificate o			ental Hy		0000	16150
5 5 5 5		Decedent's Name (First, Middle)	, Last)			incare o	Deali		2. Date of D	Reg. No	0/ 1/1/	3. Time of Death
Physic /Med		Ruth P Ha	arrison						Month May	11 ^{Da}	2007	8:15 A M
Exami		4a. Facility Name (If not institution	, give street and numb	ber)		4b. City, Town	, or Location	of Death	ziczy		c. County of Death	
	19	Cherry Lane Nu	rsing Cent	er		Laure	1			1	Prince Ge	orge's
Funera		-	6. Sex 7 1 ☐ M 2 ☐ F	. Age (In yrs. las	- /	If Under 1 Yes		24 Hrs. Min.	8. Date of Bi	irth	9. Birth	place (State or Foreign
Director		250-88-9418 Usual Residence of Decedent	X	86	Yrs.				July 1	0,]	1920South	Carolina
rland ow		10a. State 10b. County		10c. City,	Town or Lo	cation					T	10d. Inside City Limits
Man H sh	to	MD Prince	e George's	Laure	<u>-</u> 1							1 □Yes 2 □ No
th the or 28s	Director	10e. Street and Number				10f. Zip Code	9			10g. C	itizen of What Cou	ntry?
ith wi 23a (ust b	ral	9001 Cherry La	ne			2000	77			US	SA	
r des tems	Funeral	11. Marital Status	Armed Forc		13.1	Was Decedent of Yes, specify C	f Hispanic Ori	igin? (Spec	cify Yes or N	0-	14. Race - Americ Black, White,	
36 s affe	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🕅 Divorced	ed 1 Tes 2 If Yes, Give Year or Date	XNo		1 □ Yes 2 🛣N			, ,		Specify:Blac	
-00 hour	ed k	15. Decedent			16a Dece	dent's Usual Occ	cupation			16b k	Stac Kind of Business/In	
215 nin 72 nin "ne Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)		(Give life. l	kind of work dor DO NOT use reti	ne during mos ired)	st of workin	ng	100.1	and of business/iii	dustry
212 d with giene er tha	mo.	7	College (1-4		House	ekeeping	3			Pri	vate Hom	es
nd be file tal Hy d othy	Be (17. Father's Name (First, Middle, I	Last)				18. Mothe	er's Name	(First, Middle	e, Maidei	n Surname)	
yla ould I Meni arke	10	George Padgett							phant			
Maryland 21215-0036 nd 2 should be filed within 72 hours aff lith and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Examir traumatic event, the Medical Examir		19a. Informant's Name/Relationsh									or Town, State, Zip	Code)
e, P		Brenda Hammond 20a. Method of Disposition	- Granddai		841	Snowde	n Oaks		Laure		ID 20708	
ages nt of t: If it		1 Burial 2 ☐ Cremation		ale		sition (Name of natory or other p					ocation - City or To	,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.	1	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	**	Eveni				5/19/		Gre	enwood, Funeral	SC
Dep Dep any any any any	100	- Granna	E. Kels	berry								
-		23a. Part. Enter the disease, or	complications that cau	sed the death. I	Do not ent	er the mode of d	ying, such as	cardiac or	respiratory a	RQ.	Saluda,	SC 29138 Approximate
Physician	1	shock, or heart failure. List of Immediate Cause (Final disease or condition	•	snume. Espirato	rit Fo	11						Interval Between Onset and Death
/Medical		resulting in death)		as a consequen		ittute						
Examiner		Sequentially list conditions	b. Pr	neumonia								
sit.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequen	ice of):							
'60, % or be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C	as a consequen	100 of):							_
8760, Excate be executed oblysician and the burial-transit	ᄪ		Due 10 (6)	as a consequen	ice oi),							
	edical		d									
Box 6 leath certific	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregnancy							23d. Date of delive	anv
deatl deatle	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnar	h 2□Fetal de nt at time of deat		Ectopic pregnar Other (specify)					Month	Day Year
p.O. that the defended by the a	hys	9 🗆 Unknown	9□Unknow									
ords, P.O, Box 6 requires that the death certificate signed by the attending hould be detached for use as	by Physician/Me	Part II. Other significant condition	ns contributing to deat	th but not resultin	ng in the un	derlying cause g	jiven in Part I.		23e. Did t	tobacco	use contribute to th	ne cause of death?
Cord w requir	ted	Dementia							10	Yes 2	!□ No 3□ Prob	ably 4 Unknown
Rec The law te has b	Completed	Congestive H	eart Failu	re					24a. Was	psy	24b. Were auto	psy findings available mpletion of cause of
Vital Risidian: The certificate his									perfo 1□ Yes	ormed? 2 ☑ No	death? 1 ☐ Yes	2□ No
or Vita Physician: this certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:						(Check only o			
OF B Phys er this	7: To	27. Manner of Death	1 ☐ Inp	Injury 28	Outpatient	3 L DOA	41 Nui		e 5 Resi		6 ☐Other (Specify	γ)
ion Inding Ith. Ir: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	28c. Inj W M 1[orƙ? ⊒Yes 2.⊟N				, ,	
Division or Vital Records, for Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be done.	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 28e. Place of	injury - At home , etc. (Specify)	, farm, stre	et, factory, office	9	28	Bf. Location (Street ar	nd Number or Rura	l Route Number,
Div	Certification:								City or To			
Division To the Hospital or Attending Within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the be xaminer: On the basi and manner	is of examination	dge, death and/or inv	occurred at the estigation, in my	time, date and opinion, deat	d place, ar th occurre	nd due to the d at the time,	cause(s date an	and manner as sid place, and due to	tated. the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	<u> </u>	<u> </u>		29c. Licer	nse number	 -		29d. Da	ite signed (Month,	Day, Year)
		· Oyu	ブ`			DO	0045217	7		May	11, 2007	
3		30. Name and address of person w Adebowade Aja	,	of death (Item 23 001 Cher		,	irel. M	ID 200	——_ 007			
Sta Regist	te ar	31. Date filed (Month, Day, Year)		istrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CARL **JACKSON** AT.VTN 2007 9:20 p M May 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Mariner Health Care of Laurel Laurel 8. Date of Birth (Month, Day, Year) 11/24/1935 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 → M 2 □ F Months Days Hours FÍorida 71 097-28-5027 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or and be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXNo Capital Heights Prince George's Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 136 Daimler Drive 20743 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2□No 1959- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher Grade 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Lee Bryant Jack Hawkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capital Heights, Maryland 20743 Patricia A. Jackson / spouse 136 Daimler Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or otl 1 ☐ Burial 20XCremation 3 ☐ Removal from State West Arundel Crem. 5/18/2007 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson FuneralHome, P.A. ∠M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 day Immediate Cause (Final Physician Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 years Anoxic Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed 2 years as the burial-transit Dysphagia with FEG Status that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Be Completed by Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CVA 3 ☐ Probably 4XXVnknown 1 ☐ Yes 2 ☐ No peen HTN 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ※No 24a. Was an autonsy performed? /es 242No 1∐ Yes Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 XXNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 3 Suicide 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my original death accurred at the time. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signat e and title of certifier 29d. Date signed (Month, Day, Year) TENDIN G 50057216

31. Date filed (Month, Day, Year) State Registrar

Michael Baako, M.D.

3450 Ft. Meade Road, Suite 209, Laurel, Maryland 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HYSICIAN

2007

				State of Marylar				•	•	
			1 - For State Registrar	,		rtificate of I		_	Reg. No. 0 0 7	16155
	Dhysiai	an.	1. Decedent's Name (First, Middle, Last)					2. Date of De.	ath Day Year	3. Time of Death
	Physici /Medio			RIETE				nacy	16 2007	5.55PM
	Examir	ier	4a. Facility Name (If not institution, give s			4b. City, Town, or		ith	4c. County of Deat	h
	Funeral		Ellicott City Nur 5. Social Security Number 6. Sex		last birthday)	Ellicot	t City If Under 24 Hr	s. 8. Date of Birt	Howard h 9. Birth	nolace (State or Foreign
	Funeral Director			M 25 3 €F 98	Yrs.	Months Days	Hours Mir	Month, Da		nplace (State or Foreign untry) tria
	pu 🖈 ::		Usual Residence of Decedent 10a. State 10b. County	100 0	ty, Town or Lo	nation				10d. Inside City Limits
	Aaryla f sho	ō								1 ☐ Yes 2 No
	28a-	rect	MD Howard 10e. Street and Number	EL	licott	City 10f. Žip Code			10g. Citizen of What Co	
	within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-1 show I'ra Medical Examinar must be rodified at	Funeral Director	4846 Rollingtop Rd				21043			USA
	ems erm	Iner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or No	14. Race - Ame Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:Whi	
8	2 hour		15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/	
215	within 72 ene. than nu	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of w d)	orking		,
2		Con	12		Home	maker			Own Home	
and	Q to 0 0	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Maryland 21215-0036	should by and Menta s markad	T ₀	Unknown 19a. Informant's Name/Relationship (Ty,	ne Print)	19h Maili	a Address (Street		Inknown	er, City or Town, State, Z	in Code)
	Z sa za za za za za za za za za za za za za		Clair H. Kriete/so		2	Rollingto				21043
Baltimore,	es 1 and 2 of Health fitem 27 r othar tr		20a. Method of Disposition		Place of Dispo	esition (Name of matory or other place		Date	20c. Location - City or	
imo	Pag nent ant: I		1 ∑Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		Cemetery		/2007	Woodlawn,	MD
Salt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	M0144						mily FH Inc.
	₹0 E € 0		Jeron C.K.	cade					icott City,	
			23a. Part1. Sinter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	in. Do not en	er the mode of dyin	ig, such as cardio	Confespiratory at	D. Francisco	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consec	CIENCE OFF	c (9xc	100 Vas	cculan 1	Difeare	
	Examiner		Commence of the Commence of th	Senil	e D	ement	a			
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):					
	be executed ician and burial-transit	Exam	that initiated events resulting in death) Last	Due to (or as a consec	Tuence of):					
760,	ite be executed ysician and ne burial-transit	calE			4401100 01).					
89	× × •	edi								
Вох	death certificat e attending phy of for use as the	Physician/M	23b. was decedent pregnant	3c. If yes, outcome of pregn 1□Live birth 2□Feta		Ectopic pregnancy			23d. Date of deli	*
	0 0 0	sicis	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of a		Other (specify)			Month	Day Year
P.0	that the		9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not re-	sulting in the u	nderlying cause gry	en in Part I	23e Did to	obacco use contribute to	the cause of death?
Records,	es be	d by	Tarris digitillating solutions sol	inibating to addin but not rot	Juling III line u	nderlying cause give	en in ranti.		res 2 □ No 3 □ Pro	
50	w requir been si should	ompleted						24a. Was	an 24b. Were au	topsy findings available
Re	The lav	omp							prior to death?	ompletion of cause of
Vital		BeC	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes eath (Check only o		2010
of V	S	To	1 ☐ Yes 2 ☐ No		ER/Outpatier		er: Nursing		dence 6 □Other (Spec	eify)
o uc		lon:	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	k?	28d. Describe h	now injury occurred	
Division	ten leal tor: the	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str		Yes 2 □ No	28f. Location (5	Street and Number or Ru	ral Route Number.
<u>></u>		erti	4 Homicide determined	building, etc. (Speci	fy)	001, 1201019, 011100		City or Tou		
	Hospital 14 hours a Funeral (calc	29a. Certifier Certifying Phys	sician: To the best of my known	owledge, deat	occurred at the time	ne, date and place	e, and due to the	cause(s) and manner as	stated.
	the the opte	Aedical	one)	ner: On the basis of examina and manner stated.	adori and/or in					
•	To To	Σ	29b. Signature and title of certifier	Janus.		29c. License	60641		29d. Date signed (Month	
1					m (22a) (Tree-	1			5/17/200	1
2			Name and address of person who co	401-109	Pac	L RIVEY	Neck	Road	Baltimore	Marylan 2001
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign	ature	0			111110	1100
	Registr	ar	MAY 1 8 2007	Mayer D	100					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** John Alexander Kudrick 12:05 P ^M May 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examine Ellicott City Howard 2822 Southview Rd. 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F Days Hours 219-26-4037 70 Director Feb. 24, 1937 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Ellicott City the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2822 Southview Rd. 21042 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Government Ith and Mental Hygi 27 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kudrick Anna Zokuskie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Shirley S. Kudrick/wife 2822 Southview Rd. Ellicott City, MD 21042 Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 5/21/2007 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD M0144222. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk. Ellicott City, MD 21043 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) YOCATO 16 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Jas certificate 1∐ Yes 2X No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) After this 27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 X Natural Injury 1 ☐ Yes 2 ☐ No

Box 68760. P.O. Division or Vital Records. or Attending the Director: in by 1 within 24 hours a To the Funeral L Hospital To the

2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1\(\tilde{\tilde}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(
one)	and manner stated.

29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) May 17, 2007

30. Name and add of person who completed cause of death (Item 23a) (Type, Print)

8 2007

1051 Registrar's Signature 31. Date filed Month, Day, Year)

Colon Gia Mary Con

Medical

State

1. Decedent's Name (First, Middle, Last) Marie M. Kalski **Physician** 16, May /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Ruxton Nursing Care If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year, 7/5/1923 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2CXF 83 218-18-9106 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a, State 10b. County 10c. City. Town or Location an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at MD N/A Baltimore City Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1646 E. Fort Avenue 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Para Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony R. Kalski Mary Malecki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Andre Street, Baltimore Maryland 21230 Marie A. Boies / Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Sunal 2 ☐ Cremation 3 ☐ Removal from State May 22, 2007 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda, Jr. 1501 E. Fort Avenue, Baltimore MD 21230 ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) renal **Physician** Metas ta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day 2007

4c. County of Death

Baltimore

14. Race - American Indian,

Black, White, etc.

Education

Baltimore Maryland

Approximate Interval Between Onset and Death

neck

Specify:

3. Time of Death

Birthplace (State or Foreign Country)
 MD

10d. Inside City Limits

United States

white

1X Yes 2 □ No

9:20 PM

months?	1 ☐Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		c pregnancy (specify)		Month	Day Year	
eferin	contributing to death but not	/	g cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?	n
Disa					an 24b. Were au prior to commed? 1 □ Yes	topsy findings available completion of cause of	e
ed to medical			26. Place of De	eath (Check only o	ne)		
No	Hospital: 1 ☐ Inpatient	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5□Resid	dence 6 □Other (Spec	cify)	
n 5		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		now injury occurred		
6 Could not be determined	28e. Place of injury - A building, etc. (Sp	at home, farm, street, factecify)	tory, office	28f. Location (S City or Tox	Street and Number or Ru vn, State)	iral Route Number,	
1 Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exar and manner stated.	knowledge, death occurr nination and/or investigat	red at the time, date and pla- tion, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)	
title of certifier	n		29c. License number		29d. Date signed (Month	h, Day, Year)	
as of person who	completed cause of death (Item 23a) (Type, Print)	Fut Aue,	DALL	ms 2	1230	
th Day, Year)	7 32. Registrar's S	enature			,		
	1	ORIGIN	ΔΙ				

State Registrar 9 Unknown

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

signed by t

certificate

this

After

24 hours after death e Funeral Director:

within 24

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Completed

Be

Certification: To

Medical

		•	For State Registrar		, iai.a.,	Cei	tificate	of Dea	th		Reg. N	lo. 2 C	107	16158
Ph	ysicia	an	1. Decedent's Name (First, Middle, La	*						2. Date of D Month		ay	Year	3. Time of Death
	Vedic			Elmer H.	Korb			4 - 4	· (D)	May		17	2007	9:00 A.M
Ex	amin	er	4a. Facility Name (If not institution, given Glen Burnie H	,	ah		4b. City, Tov	wn, or Locat en Bur		1	4		of Death ine Ar	undel
Fun	oral				(In yrs. last I	birthday)	if Under 1 Y	ear If Un	ider 24 Hrs.	8. Date of B	irth		9. Birthpl	lace (State or Foreign
Dire			218 05 2436	1 🕱 M 2 🗆 F	88	Yrs.	Months D	ays Hou	ırs Min.	Oct. 2			Mary	yland
pu ,			Usual Residence of Decedent 10a. State 10b. County	14	IOc. City, To	wn or Lo	cation						10	Od. Inside City Limits
laryla	ed at	5		Arunde1		timo								1 ∐Yes 2 ☑ No
the M	notifi	Director	10e. Street and Number	111 411401		CIMC	10f. Zip Co	ode			10g. C	Citizen of	What Coun	try?
h with	st pe		324 West River	view Road				21225				U.S	.A.	
deat	ar mu	Funeral	11, Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13.	Was Deceden	t of Hispanio	o Origin? (Sp	pecify Yes or N o Rican, etc.)	0-		ce - America	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show	Examine	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 ☐ No If Yes, Give Year or Dates:			1⊡Yes 2⊠x					Specif		
72 ho natur	licai	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	6a. Dece	dent's Usual C kind of work of DO NOT use r	ccupation	most of wor	king			lusiness/Ind	•
Aithin he.	e Mec	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	,		DO NOT use r inter	etired)		ŭ	1	.aeıı cinti	-	Deposit
e, Mal ylalla 212 1 and 2 should be filed withir Health and Mental Hygiene.	t,	S	12th 17. Father's Name (First, Middle, Las	r)				18. M	lother's Nam	ne (First, Middle				
d be i	c eve	To Be		r E. Korb					Kath	erine R	eece	<u>.</u>	,	
should be and Mental smarked o	ımati	Ĕ	19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailii	ng Address (S	treet and Nu		ıral Route Num			, State, Zip	Code)
and 2 ealth a	er tra		Marie Korb / W	ife	3	324 1	W. Rive	rview	Road	Balt:	imor	e, M	lary1a	nd 21225
Pages 1 annument of He	r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [TRamaval from State	20b. Place ceme	of Dispo	sition (Name on atory or other	of er place)		Date	20c.	Location	- City or To	wn, State
in Pa	o fun		4 Donation 5 Other (Speci		Ho1y		ss Ceme			1/2007	Ва	ltim	ore,	Maryland
Deficiency, IV permit. Pages 1 and 3 Department of Health Important: If item 27	any inj		21. Signature of Funeral Service Lice	nsee	1		2. Name and A		90	once Fu	nera	il Se	rvice Marvl	, P.A. and 21225
W 3	5j. –		23a. Parl. Enter the dise se or consock, or heart failure. List only	nplications that caused the	ne death. D							,,,,	1101) 1	Approximate Interval Between
Physic	cian	8 /	Immediate Cause (Final disease or condition							FA		RE	- 1	Onset and Death
/Med	_		resulting in death)	Due to (or as a	consequenc	ce of):								
Exami	iner	Ļ	Sequentially list conditions,	b. MUL. Due to (or as a			912674	W +	-P/C	,0126				
ted	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c. COVG	Consequence	11/A	+45	19127	F	AILUK	25			
sxecu	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequenc	ce of):								
The law requires that the death certificate be executed ate has been signed by the attending physician and	e buri	Medical		d. CANO	UR	CO	ZON	WIT	# 6	11670	1.	20	TAST	4515
rtifica ng ph	Ö	Medi	IF FEMALE:											
ath ce	or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1☐Live birth 2	☐ Fetal dea	ath 3	⊒Ectopic preg						ate of delive onth	ry Day Year
the de	thed f	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death	1 5L	Other (speci	(fy)						
that t	detac		Part II. Other significant conditions	contributing to death but	not resulting	g in the u	nderlying caus	se given in F	Part I.	23e. Did	tobacc	o use con	tribute to th	ne cause of death?
w requires been signe	ad blu	d by	CHRON	re Lun	6	D18	GAS	6		1 🗆] Yes	2 No	3 ☐ Prob	ably 4 □Unknown
vical necolos, r.o. box sician: The law requires that the death ce certificate has been signed by the attendi	2 shou	Completed	PANKIN	SON D19	TA	86				24a. Wa	s an opsy	24b.	Were auto	psy findings available npletion of cause of
The	page	mo.	DEB.	OFA G	PON	07	RALI	167	7	per 1∐ Yes	formed?	2_	death? 1 ☐ Yes	
clan: ertific	ctor,	Be (25. Was case referred to medical examiner?						Place of Dea	ath (Check only	one)			
shysle this o	al dire	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient		Outpatie		1	Nursing H	lome 5 Res				1)
ding P	funer	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		Injury	M 28C	injury at Work? 1 ∐ Yes	2 □ No	28d. Describe	e now in	jury occu	rred	
Atten death ctor:	y the	ficat	3 Suicide 6 Could not l	28e. Place of injury	y - At home,	, farm, sti				28f. Location	(Street	and Num	ber or Rura	I Route Number,
alor after	d in b	Certification:	4 ☐ Homicide determined	building, etc.	(Specity)					City or To	own, Sta	ate)		
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha	stely fills	Medical C		hysician: To the best of	examination									
o the	отріе	Mec	29b. Signature and title of certifier	and manner state	N.	10	29c. L	icense num	ber	1	29d. [Date signe	ed (Month,	Day, Year)
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noy			3921 POT	56 8T.	BA	207	MC	7-21	122				<u></u>	
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OWER MAN 2007 NNIE /Medical City, Town, or Location of Death County of Death Examiner tomore Istowi Hospita 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1**X**M 2□F Yrs Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2**X**No Baltimore, Maryland 21215-0036 1 🗌 Yes **≙** 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th 8. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be nnie wrence ute Number, City or Town, State, Zip Code) (Street and Number or Rural Ro 19a, Informant's Name/Relationship (Type 19b. Mailing Address 308, Gwynn Oak, MD 21207 onnie Lower ethod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Baltimore, MD 3 □Removal from State 21. Signature of Funeral Service I 23a. Part1. Enter the disease, or complications that caused the earth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MEUMONIA /Medical Due to (or as a consequence of): Examiner EMEJUT Sequentially list conditions, Due to for as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): The law requires that the death certificate be exe Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 2No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy page 2 certificate 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗌 Yes 2 No 1 M Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 🗌 Yes within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of bertifier m JOGINDER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2482 PITM

State

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31. Date filed (Month, Day, Year)

Registrar

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 05 2007 15 15:31 PMM Michael Lester /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air, Maryland | Editor | Maryland | Min. | Months | Days | Hours | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | M Harford Upper Chesapeake Medical Center 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 43 Director 216-74-4917 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No **Funeral Director** MD Harford Forest Hill 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code a or ıral", or items 23a I Examiner must I 2834 Grier Nursery Road 21050 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Maintenance Supervisor</u> <u>Antique Mall</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tem 27 Is marked ott ٩ Theresa Ruggiero James Lester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2834 Grier Nursery Road - Forest Hill, MD 21050 <u>Elizabeth Dziwulski (sister)</u> Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If Iter
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Highview Mem. Gdns: 05/21/2007 Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland ann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati Non-Small Cell Lung Cancer 6 months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check one) and manner stated.

that the death certificate be executed Vital Hospital or Attending Physician: ō this Division within 24 hours after deatl To the Funeral Director:

State

Registrar

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31. Date filed (Month, Day,

29b. Signatur and title of certifier

29c. License number \$45390

29d. Date signed (Month, Day, Year) MayiGth, 2007

Mame and address of person who completed cause of death (Item 23a) (Type, Print)
Who Min (h.D.) 602 South Atwood Road #200, Bol Air, MD 21014

32. Registrar's Signature

M. D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 20 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 007 Year May 15, Physician 8:05 A M Mary P. Lazowski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 2931 Willoughby Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 15, 1929 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Days Min. 1 M 2 XF 77 Baitimore, Maryland 212-28-9124 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits al Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at Baltimore Parkville 1 □ Yes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 2931 Willoughby Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: <u>۾</u> 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Westinghouse Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other th any injury or other traumatic event, the 10 Electronics 18. Mother's Name (First, Middle, Maiden Surname) Pelagia Snyder 17. Father's Name (First, Middle, Last) Be John Blackowicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2931 Willoughby Road-Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type. Print) Beverly Leonard-daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Gardens Of Faith May 18,2007 Rossville, Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES 8800 Harford Road Parkville, Maryland 21234 andral adol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer **Physician** -una /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 Certification: To 1 TYes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: filled in by the within 2

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D 25391

29d. Date signed (Month, Day, Year)

aven Blud, Baltimore no 21239 30. Name and address of person who completed cause of death (Item 23a) (Type)Print)

State Registrar

Medical

31. Date filed (Month, Day, Year)

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2007

32 Registrar's Signature

			1 - For Amend #5, perFH, Registrar	State of Mary g867, 5/31/07	/land / Depa TT <i>Cer</i>	artment of F rtificate of	lealth and I Death	Mental Hyg ғ	giene Reg. No.2	7 16162
	♣ Physici	an	Decedent's Name (First, Middle, Last	st)			C)	2. Date of Dea Month		3. Time of Death
	/Medic	cal	Kobert 4a. Facility Name (If not institution, give	e street and number)			nsford r Location of Death	May	16 200 4c. County of	D7 1605 PM
	LAAIIII	ici	Johns Hookins Bo		ical Center	0 11	imore			
	Funeral Director		223-20-4033	ex 7. Age (li	n yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Dec . 20	Year) 1919	D. Birthplace (State or Foreign Country) Virginia
	/land ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	e Man 3a-f sh rtifled	Director	MD Baltin	nore	E:	ssex				1 ☐ Yes 2X No
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:			lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc. Jhite
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ylan	Menta Menta arked atic ev	To B	James H. Luns	sford			Hatt	ie L. F	Rhea	
Maryland	d 2 shorth and the and		19a. Informant's Name/Relationship (** Ruth Lunsford			-			er, City or Town, St nore MD	
Jre,	ss 1 an of Heal item 2		20a. Method of Disposition	1	20b. Place of Dispo	sition (Name of	1	Date	20c. Location - Ci	
Baltimore,	. Page tment c tant: If jury or		12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y)	Holly H		1	/19/07	Baltim	nore MD
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licer	Heun		Name and Addre	v Funera	al Home	of Ess	Balto. MD Sex 21221
	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final					or respiratory ar	rest,	Approximate Interval Between Onset and Death
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	Examiner	er	Sequentially list conditions,	b. Encephe	alopath	4				2 weeks
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	yslclar s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatien	t 3 DOA Oth	or:	th (Check only or	ne) ence 6 □Other	(Specify)
DIVISION OF	ding Phys h. After this funeral dir		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injur Wor	y at k?		ow injury occurred	
<u> S </u>	ten leat tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be		At home, farm, stre		Yes 2 No	28f. Location (S	treet and Number	or Rural Route Number,
2	tal or / s after al Dire ed in b	Certif	4 ☐ Homicide determined	building, etc. (5		,,,		City or Tow		or ridge ridge,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or inv	occurred at the tir restigation, in my o	me, date and place ppinion, death occu	, and due to the d irred at the time,	cause(s) and mann date and place, an	er as stated. d due to the cause(s)
	To the within 3	Mec	29b. Signature and title of certifier	and manner stated	·	29c. Licens	e number	- 2	29d. Date signed (Month, Day, Year)
)			* Kendulf IV	reselly.	MD	Res	-000		May 16	,2007
	5		30. Name and address of person who Kendall Moseley MI	completed cause death			altura			
F	Sta	te	31. Date filed (Many), Day Year) 200	D 4940 Eas 7 32 Registrar's	Signature		ACTITIVE PROPERTY	PICITY	HIKI 34	<u> </u>

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 4:40 PM AUDENSLAGER DRENCE MAI 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NORTHWEST -ANDALUSTONN HOSP ITAL BALITIMENE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Director 215-14-0819 12/01/1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 □Yes 2X No Director MD BALTIMORE OWINGS MILLS 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9451 COMMON BROOK ROAD, APT. 103 21117 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify. þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY event, the Me College (1-4or 5+) Elementary/Secondary (0-12) CLAIMS EXAMINER ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ BENJAMIN OSTROW ROLOFF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4550 CHAUCER WAY, #205, OWINGS MILLS, EVELYN PRICE/ DAUGHTER MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) HEBREW YOUNG MENS 05/17/2007 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (ADDIOVASCULAR DISEASE **Physician** ATHEROGUEROTIL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 pronths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 □ No 4 Unknown 1 ☐ Yes 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 ER/Outpatient 1 □ Y95 1 Inpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majorine stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature 29d. Date signed (Month, Day, Year) MI

State

Registrar

LOURT

(20 A)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

32? Registrar's Signature

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ROTAKIN

MICHAEL

31. Date filed (Month, Day, Year)

MAY 18

Division or Vital Records, P.O. Box 68760, பு

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Funeral		5. Social Security Number 6. Se	ex 7. Age (In	yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th ay, Year)		lace (State	
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or 28e	Funeral Director	10e. Street and Number		VIII.		10f. Zip Code			10g. Citi	zen of What Cour	ntry?	
23a cust b	ral	4403 SILVERBROOK				2111	<u> </u>			USA		
er deg	nue	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 7 No	in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	0-	 Race - American Black, White, 		
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2 should and Men is marke raumatic	2	MOYSEY 19a. Informant's Name/Relationship (7)	Type. Print)			g Address (Street		ural Route Numb	per, City o	or Town, State, Zip		<u>DA</u>
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		LUBA LOSIK / EX-W	IFE	69	03	JONES \	/IEW DR.	, 1-A,	BAL	TIMORE,	MD	21209
of Hei		20a. Method of Disposition	2	Ob. Place of	Dispos	sition (Name of natory or other place	i	Date		ocation - City or To	own, State	
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tal or s afte al Dir ed in	Certification:	T TOTAL COLUMN	building, cic. (c					Only or 1				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Phase 2 Medical Example (Check only one)	nysician: To the best of m miner: On the basis of exa and manner stated	amination ar	e, death nd/or in	n occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s e, date an	s) and manner as and place, and due	stated. to the cause	(s)
To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens	-1 0 0 -			ate signed (Month)		
		gruen	フ			105	8303		Jur	7152	00/	
7		30. Name and address of person who	completed cause of death	(Item 23a)		Print) Chur	4,60	TONSON	(, N	no 2120	7	
Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1204	L.						

			For State of Maryland Registrar		rtment of Health tificate of Death			ene 0 0 7	16165
	Dhysini		I. Decedent's Name (First, Middle, Last)				ate of Death Ionth	Day Yeer	3. Time of Death 12:45 P
	Physicia /Medic		Jack L. McDade			Mar	У	11 2007	
П	Examin	er	a. Fecility Name (If not institution, give street and number) Dulaney—Towson Health Care	1	4b. City, Town, or Location	n of Death		4c. County of Deat	
	F		5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday)		er 24 Hrs. 8. D	ate of Birth Month, Day, Y	Baltimore 9. Birt	hplace (State or Foreign ountry)
	Funeral Director		216-14-3179 XXM 2□F 83	Yrs.	Months Days Hours	Min. (A	onth, Day, Y BC• 6,1	1923 Mary	yland
	pu >			. Town or Loc	cation				10d. Inside City Limits
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	the N	rect	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	ountry?
	3a or	i Di	12105 Tullamore Court		21030		Ur	nited Stat	tes
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be rediffied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic C Yes, specify Cuban, Mexico		Yes or No- 1, etc.)	14. Race - Ame Black, Whit Specify: "Nh	
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an	ld be ental ked o	To Be	John McDade		Ethe	el Forma	an		
Maryland	should and Men s marke umatic	Н	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Num.	nber or Rural Rou	ite Number, C	City or Town, State, 2	Zip Code)
	is 1 and 2 of Health a itam 27 is		Mrs. Jean McDade (Wife)		5 Tullamore		Luther	ville, Mar	yland 21030
Baltimore,	permit. Pages 1 Department of He Important: If itan any injury or oth		CE	netery, crem ns Fun			2007 Fo		, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee Jewa J. Flynn		Alteri aceful Alteri 25 York Road				
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of Vital Records,	. The law requires that the cate has been signed by the page 2 should be detache	ompleted					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
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n c	ding Ph h. After th funeral	inol	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 [Describe now	injury occurred	
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DΪ	after after Direct Jin by	Certification;	4 Homicide determined building, etc. (Specify	()	,,	, (City or Town,	State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knor and manner stated.	wledge, death tion and/or inv	occurred at the time, date vestigation, in my opinion, d	and place, and death occurred at	due to the cau the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
}	To th withir To th comp	Me	29b. Signature and title of certifier **ATherene as a solu	'B-1	29c. License numbe H005497	0.		5///0	Z
	140		80 Name and address of person who completed cause of death (Item CHOLINE USAM 20 E.	23a) (Type,	Print) Smin Rd	4209	D'm.	MD 210	93
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture	Sharker.				
	Regist	rar	MAY 1 8 2007	15.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** 17, 6:00 A M Lillian Masterson May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Middle River Baltimore Ivy Hall Geriatric Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 X F 94 Yrs 213 05 2427 April 8,1913 Pennsvlvania Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 21 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with it.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural"; or items 23a or 2. and injury or other traumatic event, the Medical Examiner must be monore. S A A .

14. Race - American Indian, Black, White, etc. Apt 107 21221 5 Brett Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Meat Packer Meat Processing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chauncey Lewis Fannie Baer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 530 Dorsey Avenue Baltimore, Maryland 21221 Dorothy Moore (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 5/19/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licenses whal 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COSCLEROTIC CARDIOVASCILAR
CONSEQUENCE OF):

DISEASE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for use as the burial-transit and After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No To the Hospital or Attending Physician: within 24 hours after death.

Ye the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 27 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: A completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 17, 2007 D27188

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 1 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Dr. Savinder Julka M.D. 2 Market Place Baltimore, Maryland 21222

Physician Modifical Examiner Laurel Regional Hospital Laurel Regiona				1 _ State	laryland / Depa			d Mental Hy	2.0	0.7	16167
Bernard P. Merceon Reciprocal Provided P. Merceon Reciprocal	1	44		Registrar 1 Decedent's Name (First, Middle, Last)	Cel	lineate of	Dealli	2 Date of D	Reg. No	0 1	3 Time of Death
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The state of the	≥,	and ealth n 27 her tr	9					urel, MD	20707		
Physician Medical Examiner Part of the pa	ore	Jes 1	. 2	·	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location -	City or Tov	vn, State
Physician Medical Examiner Part of the pa	Ē	men tant: jury	13	4 □ Donation 5 □ Other (Specify)	Ivy Hill			21/2007	Laurel	, MD	
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Physician Modical Examiner The following in death) The following in death T		□□= 60		James Varildian						20707	
Part Congestive Heart Failure Congestive Heart Failure	Ŗ.			shock, or heart failure. List only one cause on each	ed the death. Do not enti line.	er the mode of dyir	ng, such as car	diac or respiratory	arrest,		Interval Between
Due to (or as a consequence of): Sequentially list conditions cause. Finer Underlying cause. Einer Underlying resulting in death) Last Sequentially list conditions cause. Finer Underlying cause. Einer Underlying Einer Underlying Cause. Eine				disease or condition a. COI		art Failu	re			[Onset and Death
Sequentially list condition, where the property of the past 12 months? Sequentially list condition, where the past 12 months? 23d. If yes, outcome pf pregnancy 1 live birth 2 Fetal death 3 1 live birth 2 1 live bir				Due to (or a							
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State Old Spring and	ŏ	h cer endin use	In/	23h Was decedent pregnant 23c. If yes, outcom		1r			23d. Dat	te of deliver	у
25. Was case referred to medical examiner? 26. Place of Death (Check only one)	m .	deat e att	sicis	1 Yes 2 No			/		Mo	nth [Day Year
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The state of the s	<u> </u>	lcian certifi ector	Be	examiner?		I out		Death (Check only	one)		
1 X Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 32 Registrar's Signature 31. Date filled (Month, Day, Year) 32 Registrar's Signature 31. Date filled (Month, Day, Year) 32 Registrar's Signature 31. Date filled (Month, Day, Year) 32 Registrar's Signature 32 Machinery 33 Machinery 34 Month, Day, Year) 35 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 32 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29d. Date signed (Mo	ō	Phys this al dir		I K Inpai			4 🗆 IVUISII				<u> </u>
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The state of the s	S	death ctor: y the	ical	3 Suicide 6 Could not be 28e. Place of in	iury - At home farm stre		Tes 2 110	28f Location	Street and Numb	or or Pural	Pouto Number
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	2	after after Dire	ertii	4 ☐ Homicide determined building, €	tc. (Specify)	ou, ruotory, omoo				ei oi riuiai	rioute ivambel,
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		/	İ	30. Name and address of person who completed cause of	death (Item 23a) (Type, I	Print)					
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						was s					

DHMH 17 Rev 1/2001

Physician /Medical **Examiner**

permit. Page Department o Important: If any Injury or

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-trar

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Records, Division or Vital death. Director: after

Certification: To

the Funeral Dire To the Hospital of within 24 hours at To the Funeral D

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

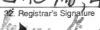
4W. ROLLIK: CROSSROADS \$ 100, BALTO. MD21228 C. ONE.

State Registrar

30

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 3:55 AM William 65 /Medical 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Mary land Medical Cente Baltemere If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number Date of Birth (Month, Pay, Year) 03/18/1956 7. Age (In yrs, last birthday)
51 yrs Birthplace (State or Foreign Country) **Funeral** Sex 12 M 2□ F Days Months 216-68-6259 Director Vrs MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at MD Director Baltimore Parkville 1 ☐ Yes 2 No 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after deeth with It Dapartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23s or 20 and injury or other traumatic event, the Madical Exempted Page. 10f. Zip Code 10g. Citizen of What Country? 1317 Taylor Avenue 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cab Company Elementary/Secondary (0-12) College (1-4or 5+) Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Warren Myers, Sr. Beatrice Elliott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bonnie Lawler/Sister 9132 Lenning Lane Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 17 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State Chesapeake Crematory Inc. 2007 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-Wh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage **Physician** liver /Medical Due to (or as a consequence of); Examiner civrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death signed by the e 5 Other (specify) 1 ☐ Yes 2 🗷 Ño 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed WITH COMPLICATIONS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?
1 \$\frac{1}{2}\$\text{OYes} 2 \subseteq \text{No}\$ Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Driver of motor yethich struk

chiert

281. Location (Street an Number or Rural Royte Number,
City or Town, State) crom well by del Rd/ 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 💢 No neral Director; A 2 Accident -12-07 tound 22:30P 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, fictory, office building, etc. (Specify) Road cub Hill Rd To the Hospital within 24 hours e To the Funeral I TOWLOW 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar S. Greene St. Bultimore MD 21201

30. Name and addrest of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

07-03617 Dad

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_		E	Registrar		Ce	rtificate c	of Death					Reg. No.		
Physi edical Exa		er	1. Decedent's Name (First, Middle,La Daquan A. Moore						4		Date of Dea Month May 11, 2	Day 2007	Year	3. Time of Death 1155 hrs
			4a. Facility Name (if not institution, 9 University Hospital	ive street and number	r)		4b. City, To Baltimo		ocation of	Death		4c.	County of Deat	h
Funer	al	7	5. Social Security Number 6. S	Sex 7. A	ge (In yrs. I	ast birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	irth(MM/E		rthplace (State or
Direct				X M 2 F	25	Yı	Months	Days	Hours	Min.	July 20	, 198	Forei Co	gn puntry) New York
any			Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loca	ation					-		10d. Inside City Limits
≥	-11	1												1 X Yes 2 No
yland - f sh	ouc	בֵּוֹלְ בַּוֹלְ	Maryland 10e. Street and Number		Balt	imore	1406 7im C					10- 0:4:-	en of What Cou	
Mar 788	ed a	Director					10f. Zip C							ii iu y ?
ith the Maryland			3600 Elandro Avenue				2120					U.S.A		
th wi	pe	Funerar	11. Marital Status 1 X Never Married 2 Marrie	12. Was Deceder Armed Forces			as Decedent Yes, specify					0-	 Race - Amei White, etc. 	rican Indian, Black,
er dea		∄		1 Yes :	2 X No		Yes 2	٦					Specify: Bla	ck
rs afte	in in	≧ -	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:	ampleted)		ent's Usual O			ad of wor	k dana		ind of Business	
hour "nat	Exa	ᆰ	Elementary/Secondary (0-12)	College (1-4 or			most of worki					TIOD. K	ind of business	industry
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d with	E Me	Completed by	17. Father's Name (First, Middle, Las	st)		3646		18	B.Mother's	Name (F	irst, Middle,			
215 e file tal H ked o	1,0	ğ	Ralph Gibbs					į	Lynet	te Mo	ore			
21 buld b	ic eve		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street	and Numb	er or Rur	al Route Nu	mber, Cit	y or Town, State	e, Zıp Code)
MD 12 sh th and 127 is	unta	1	Creola Moore (Gran	dmother)		104-39	205th	St.,	Holli	s, NY	114	12		
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	티	Γ	20a. Method of Disposition			Place of Dispo crematory or o		of ceme	etery,	E	Date	20c. L	ocation - City o	Town, State
TOPages	<u>ڦ</u>		1 X Burial 2 Cremation 3 4 Denation 5 Other Specif	t-manual and a second	Jaic	elawn Me		Park	М	av 19	, 2007	Farm	nington, l	NΥ
altin mit.] porta	<u>1</u>	t	21 Signature of Funeral Service Lic-		1	22.	Name and A	ddress c	of Facility	_		1		
T P P	Ξļ		X Jennie (The	Mun	_	1 Ro	y L. Gi 91 - 02 Li	lmore nden	e Fune Blvd.	ral H . St.	ome Albans	, NY	11412	
Physicia		ı	23a. Part I. Enter the disease, or con failure. List only one cause on	nplications that cause	ed the death	. Do not enter	the mode of	dying, s	uch as car	diac or re	espiratory ar	rest, sho	ck, or heart	Approximate Interval Between Onset and
/Medic Examin	_	1		a. Gunshot Wour	nd To Th	e Chest								Death
·	51	1	or condition resulting in death)	Due to (or as a con-	sequence o	of):								
	Н,	اي	Sequentially list conditions, if any, leading to immediate	b Due to (or as a con	seguence (٠٤/٠			_					
			Disease or injury that initiated	E.	isequence (21 /.								94
LUA.	sit	Examine	events resulting in death) Last Due to (or as a consequence of):											
execute an and	rial - transi	dicar dicar	d. UNPENDED AMENDED									 		
O, e be e	burial			AMENDED										
876 tificat ng ph	as the	lan/Med	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outco	ome of preg		etal death	3	Ectopic p	oregnanc	v		. Date of deliver Month	Ty Day Year
Box 68760, death certificate be the attending physicil	r use	۷I	past 12 months?		at time of de	eath 5 (Other (Specif	y)				- 1		
Be dear	hed for	5	1 Yes 2 No 9 Unknow	9 Unknown							00 00			
, P.O. Beines that the designed by the	detac	2	Part II. Other significant conditions	s contributing to dea	ath but not r	esulting in the	underlying c	ause giv	en in Part	. 1.			No 3 Pro	the cause of death?
S, F										_	24a. Was			utopsy findings available
cords, law requir	2 shor	bie									auto			completion of cause of
Records, The law require	page	Completed	_								1 🗸 Yes		parameter and the second	es 2 No
tal Rection: The		ae l	25. Was case referred to medical examiner?	Hoonital				10	of Death (C	Check onl	y one)	_		
of Vital ng Physician: After this certi	al dir	٩L	1 🗸 Yes 2 No			ER/Outpatie					Home 5	Resider		er:
~ :≣ . ``.	he funeral	Certification:	27. Manner of Death 1 Natural 5 Pending		njury (Year) 7	28b. Time of 1108 hrs			at Work?	lSı	ubject sh		ry occurred Olice	
Division tal or Attendir is after death.	in by the	<u> </u>	2 Accident Investiga 3 Suicide 6 Could no	28e Place of	Injury - At h	ome, farm, str	eet, factory, o	ffice bu	ilding, etc.	28			nd Number or R	ural Route Number, City
ital o	filled		3 Suicide 6 Could not be determined (Specify) Local Street correct (Specify) Local Street 2700 West North Avenue, Baltin									enue, Baltimo	re, MD	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely f		(Oncon only	ician: To the best of r	-	-								
To the within 2	con	Medical	29b. Signature and title of pertifier	and manner stated					number				Date signed (Mo	
	1		1/1/10	UN	10			D.C.M					12, 2007	, ,,,,
		-	30. Name and address of person who	o completed earlies =	death /Itc-	n 23a\								
4				sistant Medical E		-	nn Street,	Baltin	nore, M	D 2120)1			
	Stat	e :	31. Date filed (Month, Day Year)	32. Registi	rar's Sig nat	ure)			-				

			State of Maryland / Dep 1- State Registrar Amend Item 24a per verb., 886/		-	•	16171
				rtificate of Death		No.	C. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last) Ophelia Mase Marich			2 2007	3. Time of Death 13: 45 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			GENZSIS HOMZLOOD CONTOK	BALTIMORE			
	Funeral Director		5. Social Security Number 1 1 M 2 1 F 7. Age (In yrs. last birthday 1 M 2 1 F 1 M 2 1 F 1 M 2 M 2 M F 1 M 2 M 2 M F 1 M 2 M 2 M F 1 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea	9. Birthp	lace (State or Foreign try)
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	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Coun	ntry?
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	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Americ Black, White,	
9	or its	正	t Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	rticari, etc.)	Specify: 7/	etc.
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an	Mental Merkad o	To Be				n 117	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Rura	il Route Number, Cit	y or Town, State, Zip	Code)
_	and 2 ealth a n 27 is		Dehroh J. Young / Niece 35/1	Stoney Creck Ct,	Owings,	mulismo	21117
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or othar tr once.		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition			Location - City or To	own, State
E	permit. Pages Department of I Important: if it any injury or o				2007 B	altimore	mi
alti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	orh 59.	ugh C. Gir	eine junera	a Service
m	Depar Impo any ir once.		Vaugha C. Druene 8	7 - 4 - 1 - 1	~	town MD	
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	Physician		Immediate Cause (Final disease or condition a. Raym FAIL resulting in death)	TVAC		2	Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	-V/Ce			
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687			d				
	certifi Iding Ise as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	any
Box	atter atter for u	ciar	In the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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	that ned b	y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	he cause of death?
rds	quires n sign uld be	d be	HTN		1 ☐ Yes	2 ☐ No 3 ☐ Prob	ably 4 Dunknown
Records,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Medi	CAD		24a. Was an autopsy performed	prior to co	ppsy findings available mpletion of cause of
al F	ician: The lav certificate has rector, page 2		Derrentici		1 □ Yes 2 X □		2 🗆 No
Vital	ician certif rector	Be	25. Was case referred to medical examiner?	0.1	(Check only one)		
of	Phys this ral dii	۲.	1 Inpatient 2 EH/Outpatie	ant 3 DOA 4 DATE HO	me 5 Residence 28d. Describe how in	6 Other (Specif	(y)
no	ding h. After fune	tion	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Edd. Bodolibo ilon il	, ary coouriou	
Division of	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Street	and Number or Rura	al Route Number,
Div	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	,,	City or Town, St	tate)	
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal care of my	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	F 3 F 8		AL 14	P006723	9 4	AY 9	2003
•	1/2		30. Name and adverse or erson who completed cause of death (Item 23a) (Type	a. Print) DA MALS NA	11-6 00	AD.	J U. /
	10	1	30. Name and ad a ss a ferson who completed cause of death (Item 23a) (Type C HAK 35 ST St.	to 4000 Tou	آ صيد	OF 16CM	4
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 8 2007	and a			

DHMH 17 Rev 1/2001

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07-03607 Richard Theodore	1-	Please Type or Print in Black Indelible Ink. Ens ck, Jr. State of Maryland / Department of Health : For State pistrar Certificate of Death	and Mental Hy	giene Reg. N		7 6 7
Physician	1/ 1	Decedent's Name (First, Middle,Last)		Date of Death Month Day May 11, 2007	у Үеаг	3. Time of Death 0041 hrs
Mc Al Examin		a. Facility Name (if not institution, give street and number) 4b. City, Town	n, or Location of Death		4c. County of Death	
		in front of 2020 Flintshire Road Rosedal		D. D. et al. Birdh (A.	Baltimore Cou	
Funeral Director	- 1	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		1	Foreig	gn uuntry) MD
Director	_	2 7 0 - 9 0 - 4 3 0 0 1 M 2 F 2 9 Yrs. Sual Residence of Decedent		may 6,	1170	
/ any		0a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once,	ē_	my Baltmore Perry VIII.	€ de	10g. (Citizen of What Cou	
e Mary or 28a	Director	0e. Street and Number 9 Cherry Wood Court	15515		US	19
with th		1. Marital Status / 12. Was Decedent Ever in U.S. 13. Was Decedent Company of Secretary Company of Secretary Company of Secretary Company of Secretary Company of Secretary Company of Secretary Company of Secretary Company	of Hispanic Origin? (Spe Suban, Mexican, Puerto F	ecify Yes or No-	14. Race - Amer White, etc.	ican Indian, Black,
death or iten	Funeral	1 YNever Married 2 Married 1 Yes 2 No	No specify: Dage		Specify:	-ispanse
ural",	<u>اھ</u>	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Oc	cupation (Give kind of w	ork done 16	b. Kind of Business	
5 72 hou in "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	ig life. DO NOT use retire	ea)	5 0	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once.	ompleted	7. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Surname)	17-
215- be filed ital Hyg ked off	Be	District T Nock Sp.	Ale	ida B.	Quino	
21; hould be nd Men is mar	리	I9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or R			
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nore ages I nt of H it: If it		1 MBurial 2 Cremation 3 Removal from State crematory or other place)	valPurk 5/	17/07	Baltome	ne County, MB
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	H	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and A	ddress of Facility	oneral	Senwich	P. A-
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of c	dying, such as cardiac or	respiratory arrest	shock, or heart	Approximate interval
hysician/ /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Gunshot Wounds				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	-e	Sequentially list conditions, if any, leading to immediate b	7			
	amine	cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of):				
and arted	Exa	events resulting in death) Last Due to (or as a consequence or).				
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Box 68760, or e death certificate be executed the attending physician and ed for use as the burial - transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 2. Fetal death	3 Ectopic pregna	ancy	23d. Date of delive Month	Day Year
ox 6 ath cert attendir	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specific Specific Spe	(y)			
O. B. I the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.			to the cause of death?
, P.O. ires that the signed by	d by					robably 4 Unknown autopsy findings available
ords w requires been should	Completed			24a. Was an autopsy perform	prior t	o completion of cause of ?
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ital sician: s certif irector,	Be	examiner? Hospital: Inpatient 2 FR/Outpatient 3 DC	Other		esidence 6 🗸 Ot	her: Scene
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ion ttendir death. ctor: A	atio	Pending May 11, 2007	1 Yes 2 No	28f Location (St	reet and Number or	Rural Route Number, City
Division of Vital Records, rat or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification:	28e. Place of Injury - At home, farm, street, factory, 28e. Place of Injury - At home, farm, street, factory, (Specify) Vehicle in parking lot	office building, etc.	or Town Sta	ite) Road, Rosedale,	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal – transi		29a. Certifier . To the host of my knowledge death occurred at the	time, date and place, and	d due to the cause	(s) and manner as s	tated.
To the within To the complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	binion, death occurred		29d. Date signed (
	Σ	29b. Signature and title of certifier 1 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	O.C.M.E.		May 11, 2007	
e)		30. Name and address of person who completed cause of death (Item 23a)				
4		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn S	treet, Baltimore, M	D 21201		

Registrar

31. Date filed (Month, Day, Year)

MAY 1 8 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 Jean 8:18 may 11, Brenda Nesselroad /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Caroline House for Hospice Denton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

July 16, 1948 West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 214-56-1686 58 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 20T No Caroline Ridgley Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21660 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner mist.! once. 14 Lister Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) A.A. Co. Public Schools Media Center Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MArtha Louise Godfrey Paul Page Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Lister Lane Ridgley, MD 21660 Harold T. Nesselroad / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 13°, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MEadowridge Mem. Pk. 2007 Elkridge, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, Md 21061 Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, u.e on each line. 23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner hian Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 DEctopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□No 1 TYes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the within 42 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac'

10

Registrar

State

Medical

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date/signed (Month, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29466 Pintail Drive Easton, MD 21601 David Smith, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32: Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

			1- State of Maryland		artment of I		nd Mer	-	/	7 16174
			Registrar 1. Decedent's Name (First, Middle, Last)		illicate UI	Deain	2	Date of Death	g. No	3. Time of Death
	Physici	an						Month	Day Ye	ar
	/Medic		John Jothi Pandian 4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of		May 1	4. 2007	7:58 A ^M
	Examir	ier					Death		Baltim	
			1031 Maiden Choice Lane Apt. 1 5. Social Security Number 6. Sex 7. Age (In yrs. Ja.	st birthday)	If Under 1 Year	imore	4 Hrs. 8.	Date of Birth		Birthplace (State or Foreign
	Funeral Director		220-47-4464 12M 2 F 83		Months Days		Min.	Date of Birth (Month, Day, 1/30/24	Year)	Country) nzareth, India
			Usual Residence of Decedent					1/30/24	+ No	izaretii, inura
	yland		10a. State 10b. County 10c. City,	Town or Lo	cation					10d. Inside City Limits
:	Mar	to	MD Baltimore	,	Baltimor	e				1 ☐ Yes 2 🔼 No
	1.28.	Director	10e. Street and Number		10f. Zip Code			10	g. Citizen of What	Country?
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-	dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Was Decedent of I	Hispanic Origi	in? (Specify	Yes or No-		merican Indian,
٥	or the		1 Never Married 2 Married 1 Yes 2 No		_		Pueno Rica	an, etc.)		/hite, etc.
3	nours after tural', or ite al Evantina	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		I∐Yes 2 <mark>7</mark> 2 No	Specify:			Specify:	Indian
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7	within 72 ene. then "na te Medic	ldu	Efementary/Secondary (0·12) College (1-4or 5+)	life. L	DO NOT use retire	ed)	•			
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parts.	be filed within 72 hours after death with the Marylan Hydione. 44 other then "naturelt, or fleme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)						aiden Sumame)	
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Mar	Z sn and and ts m	1 2	19a. Informant's Name/Relationship (Type, Print)						City or Town, Stat	
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5	t of t		20a. Method of Disposition 1. ■ Surial 2 □ Cremation 3 □ Removal from State	netery, crem	natory or other pla	ice)	Date	2	0c. Location - City	or rown, State
Baitimor	tant:			on Pa	rk Cemet	ery !	5/17/	07]		e, Maryland
29	Depermit Deper Impor eny in		21. Signature of Funeral Service Licensee						k Funeral	
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			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyi	ing, such as ca	ardiac or re	spiratory arre	st,	Approximate Interval Between
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٠ ×	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE:		-				1	
ŏ	ath c ittenc or us	an/	23b. Was decedent pregnant in the past 12 months? 23c. ff yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of	leath 3□	Ectopic pregnanc	:y			23d. Date of Month	delivery Day Year
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a) s	mas b d san e 2 sl	ם	Dementia				_	24a. Was an autopsy	prior	autopsy findings available to completion of cause of
	oing rnysician: The lav h. After this certificate has funeral director, page 2	Completed						perform 1 Yes 2		n? ∕es 2⊠ No
VITA	ertific actor,	Be	25. Was case referred to medical examiner?					heck only one		
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	Miter Unerg	Certification;	27. Manner of Death 28a. Date of Injury 2 1 🗡 Natural 5 □ Pending (Month, Day Year) 2	8b. Time of Injury		ork?		. Describe how	v injury occurred	
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	To the hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Physician: To the best of my knowl (Check only one) 2 Medical Examiner: On the basis of examination one)	edge, death on and/or inv	occurred at the treestigation, in my	ime, date and opinion, death	place, and occurred a	due to the car it the time, da	use(s) and manne te and place, and	as stated. due to the cause(s)
4	the the	Med	one) and manner stated. 29b. Signature and title of ceptifier		,	se number			d. Date signed (M	
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	2		30. Name and address of person who completed cause of death (Item 2)	3a) (Type, I					MD 21	112
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		•	For State Registrar	State of Marylan	•	artment of F			giene 00	7 16175
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last, EMORY Pour 4a. Facility Name (If not)institution, give Genesis Randal	ell	Libertu	4b. City, Town, o	r Location of Death	2. Date of Dea Month 5-1	Day Year 206. 4c. County of D	7 5:451
9	Funeral Director		5. Social Security Number 6. Sec. 1218-38-3290 Usual Residence of Decedent	M 2□F 64	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 9,	7, Year) 9. 1942 M	Birthplace (State or Foreign Country) laryland
the Marylar	28a-1 show	ector	10a. State 10b. County Maryland N/A 10e. Street and Number		y, Town or Lo Vans	10f. Zip Code			10g. Citizen of Whal	10d. Inside City Limits 1 (X Yes 2 □ No
ath with	unit be	Funeral Director	6225 York Road			21212			United St	ates
036 ours after de	ai', or items Examiner m	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XXNo	lispanic Origin? (Spean, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - A Black, W Specify: E	merican Indian, Inite, etc. Black
and 21215-0036 De filed within 72 hours after death with the Maryland	ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use retired	durina most of workin	ng	16b. Kind of Busine	Employers
Maryland 2 and 2 should be filed	Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last) Emory E. Powell,				18. Mother's Name Carrie H			
Mary and 2 sho	27 is mare trauma		19a. Informant's Name/Relationship (Ty Romaine E. Topp (S			-	and Number or Rural Drive Apt			e, <i>Zip Code)</i> Md., 21212
altimore,	Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show very injury or other traumatic event, the Medical Examiner must be notified at QDCs.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	lemoval from State EV	rans Fu		apel May 1			ill, Maryland
Ba Perman	Depa Impo eny ir	(1 - cars A. L	em	23	25 YORK	Road, Time	ontum, r	Maryland A	
3760, and the be executed to the bear of the base of t	Medical supplies and supplies and supplies the burial-transit	dicai Examiner	23a. Part1. Enter the diseal, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Congesti	Ve H uence of): 2Ge (uence of):	eart Fai Benal	Jue Disease	respiratory an	(est,	Approximate Interval Between Onset and Death
. Box	y the attending phy iched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
Records, P.O The law requires that the	been signed by the a should be detached for		Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	. /	e to the cause of death? Probably 4 Unknown
al Records, It The law requires t	his certificate has ber I director, page 2 sho	Completed						24a. Was a autop perfor	med? prior death	autopsy findings available to completion of cause of 1? es 2 No
Vita	s certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outnation	t 3C DOA Oth	er. 4 7 the bing Hom		ne) ence 6 ⊡Other (S	Proceify)
of Of	h. After thii funeral c	T:U	27. Manner Peath	28a. Date of Injury (Month, Day Year)	28b. Time of		y at 2		ow injury occurred	pacny
Division of Vital	ector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str		Yes 2□No	8f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
Div To the Hospital or	4 hours Funersi ely fillec	edicai	(Check only 2 Medical Exami	sician: To the best of my knoner: On the basis of examina and manner stated.	wledge, death	vestigation, in my o	pinion, death occurre	d at the time, o	date and place, and o	due to the cause(s)
Į,	To	¥	29b. Signature and title of certifier	el, mo, n		29c. Licens			5- 15	
	2		30. Name and address of person who d	impleted cause of death (Item	Libe	rty Roac	056414 I, Randa	ellstou	n, MD	21133
	Sta	ite	31. Dale filed (Month, Day, Year)	32. Registrar's Signa	ture	E.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2007 **Physician** Willis Henderson Pope May 16, 12:20 P™ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center For Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **X** M 2 □ F 248-48-5951 72 10/14/1934 Director South Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes XXNo Maryland Baltimore Director Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 819 Dorsey Avenue 21221 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ۵ Specify: Korea 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Grocery Store Butcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Oscar Pope Ellen Nita Bass ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Pope (Wife) 819 Dorsey Avenue, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory 05/19/2007 Baltimore, Maryland 22. Name and Address of Facility
Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fr heart failure. List only one cause on each line. 23a. Part1. shock Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** laRS me 50 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA PICO ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: To the Hospital or Attending within 24 hours after death. 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

harles St. Balto Md 21204

MAy 16, 2007

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** lizabeth Ma 2007 1/2 /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Villa Catonsville Baltimore Frederick Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) 9. Birthplace (State or Foreign Scountry)
S. Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Months 90 Yrs. 230-22-3098 Director Usual Residence of Decedent pamit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumetic event, it is Medical Examinar must be nothed at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Ves 2 No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 4430 21229 Funeral 14 Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3 ☐ No Specify: Specify: Black ٥ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomon Hankins Juliett Hankins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4430 Eldone Baltimore, MD 21229 Amlet daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 5-21-07 Norfolk 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature un al Service Licana 22. Name and Address of Fecility P. March Fun Fredhilton Baltimore, MD 21229 Pass 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2010 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complataly filled in by tha funeral director. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 212 Alo Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director; After thi filled in by tha funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? edical Certification: 1 DiNatural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar **DHMH 16 Rav 6/95**

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Rhymond Miller

MM

32. Registrar's Signature

Sorret

Man

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

25

8 2007

29c. License number

P47683

200

Reistersown

29d. Date signed (Month, Day, Year)

7/07

			·	For State Registrar	Amend Ite	State of 24a,	f Maryland 25 per v	/ Depa /erb	rtment of	Health and 18/07dhb	Mental Hy	giene Reg. Ng.	007	16178
		Physicia	an	1. Decedent's Name	(First, Middle, Last,						2. Date of De Month	Day	Year	3. Time of Death
		/Medic	al	4a, Facility Name (I	raySour f not institution, give	street and nur	mber)		4b. City, Town,	or Location of Dea	rnay	4c. Co	unty of Death	1.10
		Examin	er	Toseph	Ritchie		,		,	Baltin				
		Funeral		5 Social Security N		M 2 X F	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		. (Month, Da	y, Year)		place (State or Foreign intry)
		Director		Usual Residence of	7/0/		8 4	113.			10.5	1924	VIT	
		ehow	_	10a. State	10b. County		10c. City	Town or Lo						10d. Inside City Limits 1 1 Yes 2 □ No
		the Ma	Director	10e. Street and Nur	mher			bal	timore 10f. Zip Code			10g Citizen	of What Cou	
		death with the Maryland ms 23a or 28a-f ehow		4304 G	wove land	Aven	110		1	12 15		11.5	5A	,
		tems ?	Funerai	11. Marital Status		 Was Dece Armed Fo 	edent Ever in U.S rces?	S. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)		Race - Ameri Black, White	
	336	filed within 72 hours after Hygiene. other then "natural", or ite ent, the Medical Exertine	by Fi	1 Never Marri 3 Widowed	ied 2 Married 4 Divorced	1 □Yes If Yes, Giv Year or D	/θ '		☐Yes 2XN	Specify:		Sp	ecify:	
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	121	within ene. then	Completed	Elementary/Seco		College (1	-4or 5+)	-	O NOT use retir	ed)		Endad	21 60	vernment
	d 2	il Hygi other	Be Co	17. Father's Name	(First, Middle, Last)			Fig	ineer	18. Mother's Na	me (First, Middle			vernment
	ylar	ould be Menta arked	To B	Abrahan						Beulah				
	Maryland 21215-0036	d 2 shi th and th and 7 ie m treum	-	\mathcal{I}	ame/Relationship (T)	1.	Phew	19b. Mailin		and Number or F	0		1000	
7	re,	permit. Pages 1 end 2 should be filled within 72 hours after death with the Maryla Dapedrinent of Health and Mendal Hygleine. Insturelly, or item 23 a or 28a-1 ehow important: if item 27 is marked other than "naturelly, or item 23a or 28a-1 ehow arry injury or other treumatic event, the Medical Examinat must be notified at one.		20a. Method of Dis	position		20b. Pl	ace of Dispo	sition (Name of natory or other pl		Date Date		ion - City or T	
5	Baltimore,	Page ment c ant: if ury or			☐ Cremation 3 ☐ F 5 ☐ Other (Specify)	lemoval from	State	-	,	05.	15.2007	Bal	imore	mo
र के	Balt	permit. Dapert Import any inj once.		21. Signature of Fu	ineral Service Ligens	99				-				
3		40144		23a. Part1. Enter	he disease, or complete	ications that o	aused the death		128 Liber or the mode of dy				n MU	21/33 Approximate Interval Between
		Physician		Immediate Cause disease or condition	nt failure. List only o (Final In	ne cause on e	iach line. Ew D	Ste	. Ren	allivers	•			Onset and Death
		/Medical Examiner		resulting in death)	(Due to	(or as a consequ		<u> </u>	V				1,1
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0,	Вох	th cert tending r use 6	an/M	IF FEMALE: 23b. Was deceden	t pregnant		come of pregnar		Ectopic pregnan	cy		23d	. Date of deliv	very Day Year
3/0	O. E	the at	Physician/Me	in the past 12 1 ☐ Yes 2 { 9 ☐ Unknown	□No	4∐Pregr 9∐Unkn	ant at time of de own	ath 5□	Other (specify)				Month	Day 19ai
R	ď.	s thet t	by Ph	Part II. Other signit	ficant conditions co					even in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
	ords	equire sen sig lould b	ted t		Cereb		Actey	· PC	ident		10	Yes 2□N	lo 3∏Pro	bably 4 Unknown
Č.	Vital Records	has by	Completed		(110	nan	Ditey	Disecs	1		24a. Was auto perf	san 2 psy ormed?	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
Sour	tal	an: Th tificate tor, pag	Be Co	25. Was case refer	red to medical					26 Place of De	1 ☐ Yes	20 No	1 🗆 Yes	2 □ No
37	of Vi	hysici his cer I direct	To B	examiner? 1 Tes 2	No 1			R/Outpatien	. 00,001	ther: 4 Nursing	Home 5□Res		Other (Spec	withorpice
2	o uc	ding P	ion:	27. Manner of Deat 1 (2 Natural	h 5 🗆 Pending investigation	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Inj. W	ury at ork? □Yes 2 □No	28d. Describe	how injury o	ccurred	,
2)	Division	Attender deatler:	Certification;	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be	28e. Place	of Injury - At hor ng, etc. (Specify	me, farm, str			28f. Location	Street and N	umber or Rui	ral Route Number,
Jarr	Ö	ital or irs afte rai Dir lled in	Cert	4 1 Nonicide										
-		To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, paga 2 should be detached for use as the burial-trensit	Medical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami	ner: On the b	best of my know asis of examinati ner stated.	vledge, death on and/or in	occurred at the restigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
-		To the within To the comple	Me	29b. Signature and	title of certifier	1	/			nse number			igned (Month	*
				•	Phil	p K	mis		DZ	1321		51	8/0	7
		(H)		30 Name and addr	ress of person who c	ompleted caus	e of death (Item	23a) (Type,	Print)	enh	Rito	hie		
		Sta	te	31. Date filed (Mor	Vh. Day. Year)	32. F	legistrar's Signat	urge	P	- P11	MIC	1116		
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249, 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 May 18 7:54 am Dorothy Theresa Robertson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** <u>2230 Firethorn Road</u> Middle If Under 1 Year River If Under 24 Hrs Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 XF 9/24/1924 Director 219-16-8918 82 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Middle River Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2230 Firethorn Road 21220 Funeral S . A .

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Oil Company <u>Secretary</u> other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Joseph Backof Catherine Gosman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Robertson (Husband) 2230 Firethorn Road Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □Cremation 3 □Removal from State 5/21 2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland <u>Oak Lawn Cemetery</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Hom 1407 Old Eastern Avenue 23a. Part1. Enter the disease, or complication that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smoother, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardia /Medicai Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Llamento 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

Rovald

31. Date filed (Month, Day, Year)

Phon alk Uttavasco MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

0-28097

9114 Philadelphia Rd. Suite 108., Balt., Md. 2123.

	State of Maryland / De	partment of Health and Mental							
Physician /Medical	1. Decedent's Name (First, Middle, Last) Terrie Darlene Ray	Mon May	13, 2007 8:25 P M						
Examiner	9703 Shuttle Court	4b. City, Town, or Location of Death Upper Marlboro	4c. County of Death Prince George's						
Funeral Director	5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 F	y) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. Jul.	o of Birth 9. Birthplace (State or Foreign Country). y 19, 1962 Washington DC						
e Maryland illied at	10a. State 10b. County 10c. City, Town or	Location Marlboro	10d. Inside City Limits 1 ☐ Yes 2 🙀 No						
h with the Mai 13s or 28a-f s at be notified		10f. Zip Code 20772	10g. Citizen of What Country? United States						
be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or tlems 23s or 28s-f show avant, the Medical Examinar must be rotified at a Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 ☐ Yes 2 √ No Specify: 	s or No- lotc.) 14. Race - American Indian, Black, White, etc. Specify: Afro American						
ed within 72 hor ygiene. In the Medical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry						
Hygi ther int.		DK 18. Mother's Name (First, I	DC Government Middle, Maiden Sumame)						
should be ind Mental s marked o umatic ave	David Donald Ray	Mary E. S							
nd 2 sh alth and 27 is n r traun		iling Address (Street and Number or Rural Route 320 Chestnut Oak Lane,							
Pages 1 and 2 should nent of Health and Menint: If item 27 is marke int or other traumatic.	20a. Method of Disposition 1 M08urial 2 Cremation 3 Removal from State 20b. Place of Discemetery, or cemetery, osition (Name of Date rematory or other place)	20c. Location - City or Town, State							
t. Pa rtmen rtant: njury	'4 □Donation 5 □Other (Specify) Resurre 21. Signature of Funeral Service Lizensee	ection Cemetery May 19,	2007 Clinton, Maryland eral Home, Inc 6633 Old						
Depar Depar Impo any ir	MyDPul moors	Alexandria Ferry Road,	· ·						
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Interval Between Onset and Death							
oate be executed by sician and the burial-transit dical Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):								
irres that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2\(\overline{\text{ZN}}\)No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	∃⊟Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year						
requires that een signed b nould be deta	Part II. Other significant conditions continuing to death but not resusting in the	underlying cause given in Part I. 23e	Did tobacco use contribute to the cause of death? □ Yes 2 No 3 Probably 4 Unknown						
aw as b 2 st		1_	autopsy performed? Yes 2√ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No						
全 道台 ト	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident	of 28c. Injury at 28d. Des	x Residence 6 □Other (Specify) scribe how injury occurred						
oital or Attanding P urs after death. Iral Director: After lled in by the funers	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	City	ation (Street and Number or Rural Route Number, or Town, State)						
n 24 hou he Funa pletely fil	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)						
within To the compl	29b. Signature and title of certifier wells	29c. License number 9 52 7 (7	29d. Date signed (Month, Day, Year) 5/15/2007						
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type Harminder Sethi, MD 7350 Van Dusen 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Road #220, Laurel MD 2	20770						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1650 M Verna Jean Reilly May 10 roog 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1 ALBOT THE MEMORIAL HOSPITAL EASTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Hours 1□M 2XX Pennsylvania 174 24 4136 Dec 27, 1929 Usual Besidence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2014 Darnell Court 20602 United States Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN Stella Beres 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Reilly (Spouse) 2014 Darnell Court, Waldorf, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Lee Crematory May 12, 2007 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 663301d 21. Signature of Funeral Service Licenses nus M0/457 Alexandria Ferry Road, Clnton, MD 20735 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PERFORATED VISCUS

Physician /Medical **Examiner**

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

မှ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturar" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ang long.

Maryland 21215-0036

Baltimore,

ours after death.

neral Director: A
filled in by the fu

Sequentially list conditions, and leaving to min admits cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)	A suence of jr			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	cause given in Part I.		ise contribute to the cause of death? ✓ No 3 ☐ Probably 4 ☐Unknown
				24a. Was an autopsy performed? 1∐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐	ER/Outpatient 3 ☐ □	OOA Other: 4 Nursing I	lome 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specification)	ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, e)
29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	slcian: To the best of my kno iner: On the basis of examina	owledge, death occurre	d at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s)) and manner as stated. d place, and due to the cause(s)

29c. License number

219 South Washington Street, Easton, MD

00059487

29d. Date signed (Month, Day, Year)

21601

DHMH 17 Rev 1/2001

State

Registrar

within 24 hours a

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

John Botsis,

8

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY Ricky Robertson 12. 2007 7:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Medical Center Towson Baltimore 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 11√2 M 2 □ F 51 240-04-0702 Director 4,1956 Feb. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at NC Wake Raleigh 1 ∑Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 27610 604 Culpepper Ln. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: 9 Specify 3 ☐ Widowed 4 ☐ Divorced <u>American</u> Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Fabricator Factory permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sylvia High Archie Robertson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 Culpepper Ln., Raleigh, NC 27610 Deborah Robertson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Goodhope_B/C_Cem. 5/19/07 Raleigh, NC 22. Name and Address of Facility Wylie F/H P A of MB 21133 C 9200 Liberty Rd., Randallstown, MB 21133 C 4 ☐ Donation 5 ☐ Other (Specify) Signature | f Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRACEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of): **Examiner** HYPERTENSIVE EMERGENCY Cayer thally not be officed, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 94 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Nipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled i 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FRANCIS KHOO. M. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

7601

Registrar's Signature

OSLER DRIVE

29c. License number

D30263

TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND

07-03648 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Anna Mildred Roberson 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 12, 2007 Anna M. Roberson Medical Examiner Gen Burne Of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel 179 Virginia Lane #L 8. Date of Birth (MM/DD/XYYY) 9. Birthplace (State or Foreign If Under 24Hrs 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Davs oreign 19,1 Country) Maryland Director Dec. M 2XF 220-24-4527 77 - 78 Vrs Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County anv Glen Burnie Anne Arundel 23a or 28a-f show notified at once. Maryland imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 United States 179 Virginia Lane, Apt. L. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11, Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X No Yes White 3 X Widowed Yes 2 X No specify: Specify: If Yes. Give Year 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Personel Services 12 Hairdresser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unknown) (unknown) Bamberger Anna Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6809 Arrowpoint Cove, Austin, TX 78759 John Roberson / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date ment or aportant: If it crematory or other place) May 15, Burial 2 X Cremation 3 Removal from State Catonsville, Maryland 2007 Metro Crematory, Inc. Other Specify Donation 5 pature of Funeral Service Licensee 22 Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X AMENDED 4b, perME, C867, 5/18/07, WS// #7,8. perFH, C867, 5/22/07 TI UNPENDED attending physician or use as the burial 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death <u>ج</u> Completed has

Division of Vital Records, P.O. Box 68760, this After To the Funeral Director: completely filled in by the within 24 hours after

Be

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Certification:

Medical

State Registrar

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year)

Inte.

Yes 2 No 9 Unknown	g Unknown	5 Other (S	pecify)			
art II. Other significant conditions	contributing to death but not r	esulting in the underlyi	ng cause given in Part I.		e contribute to the cause of death? No 3 Probably 4 Unknow	
				24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings availar prior to completion of cause death? 1 Yes 2 No	of
5. Was case referred to medical			26.Place of Death (Check	only one)		
examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nurs	ng Home 5 Residence	ce 6 🗸 Other: Scene	
7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury	coccurred	
2 Accident Investigation 3 Sulcide 6 Could not be determined	28e Place of Injury - At h	ome, farm, street, facto	ry, office building, etc.	28f. Location (Street and or Town, State)	Number or Rural Route Number, (City
ne) 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a					

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Time of Death

1845 hrs

10d. Inside City Limits

1 Yes 2 XNo

Approximate Interval

Between Onset and

Death

Year

29d. Date signed (Month, Day, Year)

May 13, 2007

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener

		1 - For State Registrar			ary tarrar .	Certif	icate of	Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.			
Disersi			ne (First, Middle, La	-					2. Date of De		Year	3. Time of I	Death
Physic /Med		WILLI	MM	RAT	CLIFF	E			MY	16	FOOS	9:30	Дм
Exam		4a Facility Name 4715 Eli	If not institution, giv. Son Avenu	e street and number) 1 e		41		r Location of Death Baltimore			County of Death .ltimore	City	
Funera Director		5. Social Security 087-16-2	Number 6. S	Sex 7. Ag	e (Invrs. last bi		f Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir			place (State or ntry)	Foreign
р »		Usual Residence of	of Decedent 10b. County		10c. City, Tow	um or Locati	ion					10d. Inside Cit	v Limits
anyla shov	5	MD	Baltimo	re City	Baltin		ion					17 Yes	
vith the N or 28e-f	Direct	10e. Street and No.	umber son Avenu	е			10f. Zip Code 21206			10g. Citiz	zen of What Cou		
s 23e	- La			12. Was Decedent	Ever in 11 S	12 Was		lispanic Origin? (Sp	posity Voc or No		14. Race - Americ	ean Indian	
1215-0036 within 72 hours after death with the Maryland one. than "natural; or Items 23e or 28e-f show the Macinal Exemples of	by Funeral Director		ried 2 Married 4 □ Divorced	Armed Forces? 1 DYes 2 If Yes, Give Year or Dates:	No	If Ye	Yes 2 100	Specify:	Rican, etc.)		Black, White, Specify: Whit	etc.	
2 hou	led		15. Decedent's E	ducation		a. Deceden	t's Usual Occup	ation		16b. Kir	nd of Business/In	dustry	
21215-0036 d within 72 hours aff giene. er than "natural; or if the Westeal Exerci-	Completed	(Spe	ondary (0-12)	College (1-4or	5+) T e	(Give kind life. DO eller	d of work done o NOT use retired	during most of world)	king	Bank	cing		
Hygied y		17. Father's Name	(First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden	Sumame)		
land be lid be riked o	To Be		Radcliff					Sara					
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth rtraumatic event		19a. Informant's N Corita R	Name/Relationship (adcliffe/W	Type, Print) 'ife	19i 4	b. Mailing A	Address (Street lison A	and Number or Ru venue Ba	ral Route Numb ltimore	er, City or , M D	7 Town, State, Zip 21206	Code)	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinational be institled at				Removal from State	20b. Place of comete Chesa	erv cremati	nry or other plac	ory Inc.	May 18 2007		cation - City or To		d
Balti permit. Departm Imports any inju		21. Signature of F	uneral Service Lice		01443			ind Frühera Pastures				yland 2	1286-
		23a. Part1. Enter	the disease, or com	plications that caused one cause on each li	the death. Do	not enter t	he mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Betw	yeen
Physician		Immediate Cause	(Final	MYOURD		TAD C	TIGAL					Onset and D	Death
/Medica		resulting in death			a consequence		11017					1 Z HOCK	
Examine		Sequentially list c	onditions.	b	1								
p tis	ine	Sequentially list of any, leading to it cause. Enter Und	mmediate lerlying	Due to (or as	a consequence	∋ of):							
xecute and il-tran	Examiner	that initiated even resulting in death)	ts	c Due to (or as	a consequence	e of):							
Box 68760, eath certificate be executed attending physician and for use as the buriat-transit				d		,							
687 ifficate g phy as the	Medical												
Box eath cert attending for use a		IF FEMALE: 23b. Was decede		23c. If yes, outcome	of pregnancy 2 Petal deat	h 3∏Eo	topic pregnancy	,		2	23d. Date of deliv		
. 0 0 0	Physician/	in the past 1. 1 Yes 2 9 Unknow	□No	4□Pregnant a 9□Unknown			ther (specify)				Month	Day Y	'ear
d the did the	Phy			contributing to death b	out not resulting	in the unde	riving cause giv	en in Part I.	23e. Did 1	obacco u	se contribute to t	he cause of de	eath?
ds, F	d by	DEMENT			•		, , , , ,		1 🗆	Yes 25	3 √No 3 □ Prol	oably 4 □U	Inknown
cord w require been sig	Completed		S						24a. Was	an	24b. Were auto	posy findings a	available
The law sete has b page 2 sl	пр					·			auto	psy ormed?	prior to co	impletion of ca	luse of
Vital Fician: The certificate rector, pag	o C	25. Was case refe	arred to medical					26. Place of Dea	1 ☐ Yes	2 3 No	1 🗆 Yes	2 No	
of Vita Physician: rihis certific ral director,	0	examiner?		Hospital: 1 ☐ Inpatie	ent 2 ER/O	Outpatient	3 DOA Oth	OF			S □Other (Specia	fy)	
g Physicar this neral di	n: T	27. Manner of Dea	ath	28a. Date of Inju (Month, Da		Time of Injury	28c. Injur Wor	y at	28d. Describe			-	
ion inding lath.	atlo	1 🖾 Natural 2 🗆 Accident	5 Pending investigatio	n	, , , ,	injury		Yes 2□No					
Division of Vital Records, all or Attending Physician: The law requires to alter death. I Director: After this certificate has been signed in by the funeral director, page 2 should be.	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe, Flace of III	iury - At home, f ic. (Specify)	farm, street	, factory, office		28f. Location (City or To		d Number or Run)	al Route Numb	ber,
Division of Vita No the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical 0	29a. Certifier (Check only one)		hysician: To the best miner: On the basis o and manner st	f examination a)
To th within To th	Me	29b. Signature an	d title of certifier	11	/		29c. Licens	e number		29d. Dat	e signed (Month,	Day, Year)	
		1 de	nen	Herast	~ MT		D62	2037		MAY	16 20	07	
1117		30. Name and add	dress of person who	completed cause of	death (Item 23a)) (Type, Pri	nt)	203Z JURCH					3.1
4'		JENNIFE	=R+(AYK	SH1, 5305	HOPKI	NS E	AYVIEW	JURCH	E BAL	TWO	RE MD	2122	7_
s	tate	31. Date filed (Mo	nth, Day, Year)	32. Registr	ar's Signature	1 4	2-		,				

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 4:101 M ELLEN ROBERTS MAG 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 9 / 0 5 / 1 9 2 9 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ XT 78 Yrs Newfoundland 213-80-6651 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County · 28a-f show notified at 1 ☐ Yes 2 No MD Director Howard Fulton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 3 r must be n United States 12401 Limekiln Road 20759 death Funeral 14 Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after deal nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items; ury or other traumatic event, the Medical Examiner muny or other traumatic event, the Medical Examiner muny. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Caucasian Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Follett Mary Tobin James ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ${
m A1C3T5}$ 19a. Informant's Name/Relationship (Type. Print) 58 Monkstown Rd St. Johns, Newfoundland Alice Buckingham/Sister 20b. Place of Disposition (Name of cemetery, crematory of other p. Metropolitan Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Buriat 2X Cremation 3 ☐ Removal from State 05/11/07 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McKinnon & Bowes Ltd. 21, Signature of Funeral Service Licenses 162 Wicksteed Ave. Toronto, OntarioM4G2B6 Moanna Pakel. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0145 **Physician** ACUTE GASTROINTESTINAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 I I Inknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has the rector, page 2 s autopsy performed 2 No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ this œ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D51860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DNIVE JUN ATHAN FISH MO CHARTER 16700 Pay, Year) 31. Date filed (Mor Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland / [rtment of H tificate of L		id Mental Hy	giene 0 0	7 16186
4	Physici	an	1. Decedent's Name (First, Midd						2. Date of De	_	3. Time of Death
	/Medi		EISIE		ingley				may	920	7 12:45~
	Examir	er	4a. Facility Name (If not institution	on, give street and number 3820 Old Colum			4b. City, Town, or	Location of D		4c. County of I	Howard
	Funeral Director		5. Social Security Number 412.48.4858	6. Sex 7. A	ge (In yrs. last bir 78	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birt Min. Month, Da December	^h . Year) er 24 , 1928	Birthplace (State or Foreign Country) Tennessee
	and w		Usual Residence of Decedent 10a. State 10b. Count	tv	10c. City, Town	n or Loc	ation				10d. Inside City Limits
	he Maryl 28a-f sho otified al	ector	Maryland	Howard				licott City			1 □Yes 2 No
	23a or 2 ust be n	Funeral Director	10e. Street and Number 3820 Old Colum	bia Pike			10f. Zip Code	2104	13	10g. Citizen of Wha	U.S.A.
36	rs after dee I', or Items xaminer m	by Fune	11. Marital Status 1 □ Never Married 2 Ma 3 □ Widowed 4 □ Divorce	If Yes Give	No.		/as Decedent of His Yes, specify Cuba ☐ Yes 2 No	spanic Origin n, Mexican, F Specify:	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, \ Specify:	American Indian, White, etc. White
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by	15. Decede (Specify only high Elementary/Secogdary (0-12)	ent's Education lest grade completed)	16a.	Decede (Give k life. De	ent's Usual Occupa ind of work done d O NOT use retired,	ation Juring most of nemaker		16b. Kind of Busin	ess/Industry at home
and 21	12 should be filed with, h and Mental Hygiene. 7 is marked other thar traumatic event, the M	Be	17. Father's Name (<i>First, Middle</i>	Bruce Miser			1101		Name (First, Middle,	Maiden Surname) attie Nichols	
Maryla	d 2 should be th and Mental Y is marked of traumatic ever	丘	19a. Informant's Name/Relation Ms. Margaret C		aughter	. Mailing	Address (Street a	nd Number o I mbia Pik	or Rural Route Number e Ellicott City,	er, City or Town, Sta Maryland 210	ate, Zip Code) 43
ď	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 □Removal from State	20b. Place of	Disposi ry, cremi est Lav	ition (Name of atory or other place wn Memorial	Gardens	5-14-	20c. Location - City Marriot	y or Town, State Isville, Maryland
Baltir	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service		MN1797		Name and Addres Slack F	s of Facility uneral H	0.4	tt City MD 21	043
	e sa Sie	Н	23a. Part1. Enter the disease,	or complications that cause	ed the death. Do r	not enter					Approximate Interval Between
	Physician /Medical	ři	Immediate Cause (Final disease or condition resulting in death)		TryseA						Onset and Death
	Examiner				s a considuence o	01).					
ري	scuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cuse list of ying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence (
,8760,	icate be executed physician and the burial-transit	Jical	resulting in death) Last	d	s a consequence of	of): 					
.O. Box 6	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNO 9 ☐ Unknown		e pf pregnancy 2 Fetal death at time of death		Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
rds, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant condit	tions contributing to death	but not resulting in	the und	derlying cause give	n in Part I.	23e. Did to	_	te to the cause of death? Probably 4 Unknown
	(0 🗅	Completed							24a. Was a autop perfor 1 Yes	sy prio	e autopsy findings available r to completion of cause of th? Yes 2 No
Z.		o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:	it 2000	AA:A	2 DOA Othe	r·	Death (Check only or		
ō	y Physer this eral di	-	27. Manner of Death	1 ☐ Inpat	ury 28b. T	Time of	3 DOA 28c. Injury Work	4 L Nursir	ng Home 5 Resid	ence 6 LOther (a ow injury occurred	Specify)
ion	Attending F r death. ector: After by the funer	atio	1 Accident 5 Pendi 2 Accident invest	ing (Month, D tigation	ay Year) II	njury		? ′es 2 □ No			
5	ਙ ਨ ਿੰ⊑	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	minod 200. Flace of it	ijury - At home, fai itc. <i>(Specify)</i>	rm, stree	et, factory, office		28f. Location (S City or Tow	treet and Number o n, State)	or Rural Route Number,
	To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physician: To the bes Il Examiner: On the basis and manner s	of examination and	, death o	occurred at the timestigation, in my op	e, date and p inion, death	place, and due to the occurred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	Vithir To the	M	29b. Signature and title of certifi	7			29c. License	number	-	29d. Date signed (N	fonth, Day, Year)
			Willim	HOULRS	MD		DZO	789	/	1449,2	2007.
-	6		30. Name and address of person	211 6536	55 Li	Type, Pi	PATUKE	M	Columbia	ymo =	21044
	Sta Registr		31. Date filed (Month, Day, Year MAY 1 8	2007 32. Regist	rar's Signature	reel	م				

07-03727 Deandre Selmond		or Print in Black Inc of Maryland / Depa	th and Mental H							
Physician/	Registrar 1. Decedent's Name (First, Middle,La		tificate of Deat	<u>'</u>	2. Date of Death	Voca	Time of Death 2250 hrs			
Medical Examiner	4a. Facility Name (if not institution, gi University Hospital	ve street and number)	4b. City, 1	own, or Location of Death	May 15, 2007	. County of Death				
Funeral	5. Social Security Number 6. S	ex 7. Age (in yrs. la		er 1 Year If Under 24Hrs		DD/YYYY) 9. Birthpl Foreign	ace (State or			
Director	Usual Residence of Decedent	M 2 F	Yrs.	3 Days Hours IVIII	12-21-1989	Countr	100			
nd thow any cc.	10a. State 10b. County	10c. City,	Town or Location	MI			d. Inside City Limits Yes 2 No			
the Maryland a or 28a-f sh tiffed at once Director	10e. Street and Number 545 S Fulface	Avenue	10f. Zip	1223	10g. Citiz	zen of What Country	?			
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	11 Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.s Armed Forces? 1 Yes 2 No		ent of Hispanic Origin? (S fy Cuban, Mexican, Puerto		14. Race - American White, etc.	Indian, Black,			
irs after of miner in	3 Widowed 4 Divorce	d If Yes, Give Year or Dates:	1 Yes 2	No specify: Occupation (Give kind of	work done 16b. h	Specify: O	istry			
imore, MD 21215-0036 Pages and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. There is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of wo	rking life. DO NOT use rei	tired)	Studen	+			
ore, MD 21215-0036 ore, MD 21215-0036 or Health and Montal Hygies If item 27 is marked other than ther traumatic event, the Medical		mond		Yvette	e (First, Middle, Maiden					
MD 21. d 2 should the and Mer and 27 is mar umatic evenumatic even	19a. Informant's Name/Relationship	Type, Print)	19b. Mailing Address	(Street and Number or	2 11.	ity or Town, State, Zi	p Code) 21223			
Baltimore, MD bemit Pages and 2 sho Openment of Healment Openment of Healment injury or other traumati		Removal from State	Place of Disposition (Na crematory or other place		Date 20c.	Location - City or To	wn, State			
Baltimo permit. Pag Department Important: injury or ot	21. Signa re of Fu er I Service Lice		22. Name and 5151 2	Address of Facility	Jat'l Pike J	Baltimore	21939			
Physician /Medical	23a. Part I. Ent in the disease, or comfailure. List half one cause on a	plications that caused the death. each line.		of dying, such as cardiac	or respiratory arrest, sho	ock, or heart	proximate Interval Between Onset and Death			
kaminer	Immediate Cause (Final disease or condition resulting in death)	Multiple Gunshot Woun Due to (or as a consequence of								
i e	Sequentially list conditions,	if any, leading to immediate Due to (or as a consequence of):								
ted unsit		Due to (or as a consequence of	f):				_			
), be executed sician and urrial - trans	UNPENDED	X AMENDERME, g868,	613/07 TT							
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed than 24 hours after death. The Funcard Divisor After this certificate has been sign d by the attending physician and apletely filled in by the funeral director, page 2 should be chached for use as the burial - transfired Certification: To Be Completed by Physician/Medical Education	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregrature 1 Live birth 4 Pregnant at time of de	2 Fetal death			id. Date of delivery Month Day	y Year			
O. Boy at the death d by the attrached for V Physics	1 Yes 2 No 9 Unknow Part II. Other significant conditions	9 DIKNOWII	esulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the	e cause of death?			
S, P C						No 3 Probab				
of Vital Records, I ag Physician: The law requires ther this certificate has been signeral director, page 2 should be not To Be Completed					24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of			
tal Rician: Tician: Tician: Escrot, p				26.Place of Death (Chec						
f Vid Physic or this	1 Yes 2 No	Hospital: 1 ✓ Inpatient 2 28a. Date of Injury		DOA Other Nurs	28d. Describe how in	ence 6 Other:				
ision of Attending Physic death. rector: After the by the funeral.	1 Natural 5 Pending 2 Accident Investige	May 15, 2007	2218 hrs	1 Yes 2 ✔ No	Subject shot	Jary Good Too				
Division o Bispital or Attending 24 hours after death 24 fours after death tely filled in by the fune	3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At he		y, office building, etc.	28f. Location (Street or Town, State) 500 Block of South		- 1			
Divi To the Hospital or within 24 hours after To the Funeral Diric completely filled in		ician: To the best of my knowled er:On the basis of examination a								
To the within To the comple	29b. Signature and title of certifier	and manner stated.	. 29	c. License number	29d.	Date signed (Month	n, Day, Year)			

30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201 32: Registrar's Signature

O.C.M.E.

May 16, 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For Stete Registres Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ulli Var HN 1:21 PM 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOPKINS HOSpital Saltmore he If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 11, 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **XX**M 2□ F Yrs 019-22-0992 78 Director Massachusetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Virginia Fairfax Reston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11200 Center Post Court 20194 United States Ітетне 23в filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) NTYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: 3 Widowed 4 Divorced WWII nature 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President Manufacturing permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygies Important: if item 27 is marked other th eny lighty or other treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fabian Sullivan Helen May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Sullivan, Wife 11200 Center Post Court, Reston, Virginia 20194 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oxford Hills Crematory 05/21/2007 4 ☐ Donation 5 ☐ Other (Specify) Chester, New York 21. Signature of Fundral Service Licensee M01113 22. Name and Address of Facility Lazear-Smith & Vander Plaat Memorial Will Home, 17 Cakland Avenue, Warwick, New York, 10990 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardina eni **Physician** /Medical Due to for as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit nai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached in ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 2 No 1□ Yes ours effer death.

neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

10+

State Registrar Haspital

600 N Wolfe St. Bultmore MDZRX7

use of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ihrs Hopkins

			For 1 _ State	rieas	State of	of Marylar	nd / Depa	artmen	t of H	ealth a				gible.	
			Registrar				Cei	rtificat	e of L	Jeatn			Reg. No.	007	16189
	Physici	an	Decedent's Name (F	_	,							2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Dale	Frank		Steirer						MAY	13	2007	102:20 AM
7	Examin	er	4a. Facility Name (If no		_	*		10.		Location		21005	_	unty of Death	
			St AGR	4 -/-	told TH		to and the institution of an of	If Under	LNY	OKE,	MD 24 Hrs	8. Date of Bi	-	N/A	place (State or Family
	Funeral		5. Social Security Num		Sex 1⊠M 2□F	7. Age (In yrs.		Months	Days	Hours	Min.	(Month, Da	ay, Year)	Cou	place (State or Foreign ntry)
	Director		214-50-470 Usual Residence of De				58 Yrs.					July 6	1948	Mar	yland
land	M t			b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
Mary	-f sh	ţo	Maryland E	Raltimo	re	Ra1	timore								1 □Yes 2 ▼No
the	28a notii	Director	10e. Street and Number			Dar	CIMOIC	10f. Zip	Code				10g. Citizen	of What Cou	ntry?
h with	3a o st be	0	1033 S. E	Beechfi	eld Ave	nue			2122	29			US	SA	
5-0036 72 hours after death with the Maryland	ms 2	Funeral	11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	D- 14.	Race - Ameri	
e after	or ite		1 Never Married	2K) Married		2 □ No		ii res, spe 1 □ Yes		Specify:		rican, etc.)		Black, White,	
21215-0036 9d within 72 hours af	Exar	Completed by	3 ☐ Widowed 4 [Divorced	Year or I	Dates: Vie	tnam	1 1 1 1 1 1 2	2001110	эреспу.			Sp	ecify: Wi	nite
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12 ig	nan " Mec	du	Elementary/Seconda			1-4or 5+)									
d 2121 filed within	Hygier ther the	Š	12				Sat	ety I)ire		1. 51	/F:			torage Co.
ind be fil	d off	Be	17. Father's Name (Fin	rst, Middle, La								e (First, Middle	,	,	
yla ould	and Mental s marked o umatic eve	은	Joseph			eirer	1			Mar		Loui		Harris	
C/	is m		19a. Informant's Name					-				al Route Numb	-		
	it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exa <u>miner must be notified at</u>		Carol L. S		(Wife)	20h	1033	S. Be	eechf	ield	Ave	nue, Ba Date		e, MD on - City or T	
Baltimore,	nent of h ant: If ite ary or of		1 ⊠Burial 2 □ 0	Cremation 3			Place of Dispo							•	
time .	rtant	١,	4□Donation 5		Second Property of the Control of th	E01	idon Pa			- 1		707 udon Pa			Maryland
Bal	Department Important: I any injury o		21. Signature of Fune	rai Service Li	-		2.				2 50	, Balti	- CT (12		
			23a Part1, Enter the	discount or or	mplications that	caused the dea	th Do not on					-		1110 212	
			shock, or heart f	ailure. List or	ly one cause on	each line.	Do not en	er the mod	ie or dylin	y, such as	cardiac	or respiratory a	Allest,		Approximate Interval Between Onset and Death
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60 , C.	ysician and ie burial-transit	xar	that initiated events resulting in death) Las	t	c. Due to	(or as a conse	quence of):	TULL	<u>ِ سگالل</u>						
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. Box 687 death certificate	has been signed by the attending phys ge 2 should be detached for use as the				0.						_				
Box	nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, or	utcome pf pregr							23d	. Date of deliv	/ery
Meath We	atte	cial	in the past 12 mg	onths?	4□Preg	birth 2 Fet nant at time of		⊒Ectopic p ⊒ Other <i>(s</i> ;						Month	Day Year
P.O.	y the	ηysi	9 Unknown		9□Unki	nown									
	ned b e deta		Part II. Other significa	ant condition	s contributing to	death but not re	sulting in the u	inderlying o	ause give	en in Part i	1.	23e. Did	tobacco use	contribute to	the cause of death?
rds	n sign uld blu	d by	Elopha	peol	Concer	.1						1 🗆	Yes 2 1	lo 3□ Pro	bably 4 □Unknown
0 ≥ ≥	shor	Completed	long	to	uf o							24a. Was		4b. Were aut	opsy findings available
The is	ate has	mc d		/	7044								ormed?	death?	ompletion of cause of
	certificate rector, pag		25. Was case referred	to medical						26. Place	e of Deat	n (Check only	2□No one)	I L Tes	2□ No
or Vita Physician:	is certific director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	•	Hospital:	Inpatient 2	ER/Outpatie	nt 3 □ D0	OA Oth	or.		me 5 Res		Other (Spec	ifv)
O 4	er this		27. Manner of Death		28a. Date	of Injury	28b. Time o	of 2	28c. Injur Wor			28d. Describe			
Vision	th. r: After e funera	ţ	1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investiga		nth, Day Year)	Injury	M		Yes 2□	No				
ViS	r death. ector: A by the fu	iţi	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ZOE. FIAC	e of injury - At h	nome, farm, st	reet, factor	y, office			28f. Location	(Street and Nown, State)	umber or Ru	ral Route Number,
<u> </u>	n 24 hours after death. Ie Funeral Director: A etely filled in by the fu	Certification:	4 Di tottiloide		Dank	allig, etc. (opec	ny)					Ony of Te	wii, Otate)		
Hospital	hours inera y fille	al			Physician: To th										
e Hc	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2[one)	medical E	(aminer: On the and ma	basis of examin nner stated.	iation and/of if	ivestigation	, iii my c	ириноп, ае	atri OCCUI	reu at trie time	, uate and pla	ace, and due	to the cause(s)
70	within 2 To the I complet	Ž	29b. Signature and titl	le of certifier				1		e number			29d. Date s	igned (Month	, Day, Year)
			► KWE	y .	N·N				121	227			Mary	13	2007
	1401		30. Name and address	s of person w	no completed cau	ise of death (Ite	m 23a) (Type,	Print)			D				, , ,
	10,		SRIDHAR	6/AD	CREMM	SFA	UNES	(for	PETA	4	BAU	UNDRE	OCH ,	, 212	29.
	Sta		31. Date filed (Month,		12	Registrar's Sigr	nature					,			
	Regist	rar	MA	Y 1 8 2	007	20.00	1 for	A Para							
DHMF	17 Hev 1/2	UUT				and an extended	7	101111							
							OR	IGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State of Maryland / Department / Department / Department / Department / Department / Department / Department / Depart	artment of Health and N <i>rtificate of Death</i>	lental Hygiei Reg.	00000 10100
ŀ	Physicia		1. Decedent's Name (First, Middle, Last) Catherine Moody Scott		2. Date of Death Month May 11,	2007 Year 3. Time of Death 7:45 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Good Samaritan Nursing Center	4b. City, Town, or Location of Death Baltimore		4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 12/24/19	ar) 9. Birthplace (State or Foreign Country) NC
	ryland how at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Log MD n/a Baltimo			10d. Inside City Limits 11€1Yes 2 ☐ No
	th the Ma or 28a-f s e notified	Director	10e. Street and Number 1323 Heather Hill Road	10f. Zip Code 21239	10g.	Citizen of What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2XXIII Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	Ithin 72 ho Ie. Ian "natur Medical	Be Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Homemaker	ing 16b	o. Kind of Business/Industry Own Home
ınd 21	be filed wintal Hygier of other the event, the	Be Cor	17. Father's Name (First, Middle, Last) Ben Moody		e (First, Middle, Maid via High	den Surname)
Maryland	nd 2 should th and Mer 27 is marke traumatic	욘	19a. Informant's Name/Relationship (Type. Print) Rosaline Powell / Daughter 19b. Mail 1323	ing Address (Street and Number or Run B Heather Hill Roa	ral Route Number, Ci d, Baltime	ity or Town, State, Zip Code) ore, MD 21239
altimore,	Pages 1 and 2 nent of Health a ant: If Item 27 is ury or other trai		20a. Method of Disposition 1 Burial 2 Cremation 3 Femoval from State cemetery, cre 4 Donation 5 Other (Specify)	osition (Name of ematory or other place) emetery May 19		C. Location - City or Town, State Gaston, NC
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee	Charles L. Steve 1501 East Fort A	ns Funera venue, Ba	1 Home Inc. 1timore, MD 21230
68760,	Physician / Medical Examiner street per executed street price is the pural-transit	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	HEALT FAILURE	or respiratory arrest,	Approximate Interval Between Onset and Death
P.O. Box 687	law requires that the death certificate as been signed by the attending phy. 2 should be detached for use as the	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	uires that t signed by Id be detac	by	Part II. Other significant conditions contributing to death but not resulting in the CHANIC RENAL FAILURE	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Division or Vital Records,	The ate ha	Completed	THEL DIAMETES MELLITU	2	24a. Was an autopsy performer 1 Yes 2X	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor	th (Check only one)	ee 6 □Other (Specify)
n or	ng Ph fter th nerai	on: To	27. Manner of Death 1 → XNatural 5 → Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at	28d. Describe how	
Divisio	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rural Route Number, state)
	e Hospital 24 hours a e Funeral I etely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	29c. License number \[\begin{align*} \text{ To } \begin{align*} \text{ B } \begin{align*} 20 Comparison of the comparison of the	29d	Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type ROLEMARIE MARKET 560 LOLH	e, Print)	SHUT M	D 1239.
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	1000	INC.	7 4/471.
	Regist	rar	MAY 1 8 2007 100 100 100 100 100 100 100 100 100			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day 1. Decedent's Name (First, Middle, Last) : 05 AM **Physician** STURGILL 05 FO /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore nder 1 Year | If Under 24 Hrs. Baltimore Manor Care Health Services Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 26, 1933 **Director** 73 Maryland 218-28-4128 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Directo Maryland Harford <u>Abingdon</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 USA 2313 Old Emmorton Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ 3 ☐ Widowed 4 € Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nat any injury or other traumatic event, the Medica once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Gladys Marie Abbott Melvin Edward Utz ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8148 North Farm Rd., Fair Grove, MO 65648 f Disposition (Name of Date 20c. Location - City or Town, Robin A. Mikulan / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Air Memorial Gdns 5-17-07 Bel Air, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUD **Physician** /Medical Due to (or as a consequence of): **Examiner** MF Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 autopsy perform certificate 2 HNo or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: Nursing Home 5 Residence 6 Other (Specify) 21 No Medical Certification: To 1 TYes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation s after oc. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatute and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 venande 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 8 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Manyland Department 120b Per FH 367 5/24/07 Department Certificat 1. Decedent's Name (First, Middle, Last)	t of Health and Me of Death	Reg. !		16192
*Physi	ician dical	DOROTHY S. SCHLOSS		2. Date of Death Month I MAY 13	Day 2007	3. Time of Death 08:40 A.
Exan		4a. Facility Name (If not institution, give street and number) PICKERGILL INC. 4b. City,	Town, or Location of Death TOWSON		4c. County of Death BALTIN	MORE
Funera Directo		5. Social Security Number 215-03-9336 Output 6. Sex 1	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea 08-10-19	9. Birthp Coun 13 MAR	lace (State or Foreig try) LAND
Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location MD. BALTIMORE	TOWSON		1	0d. Inside City Limits
h with the 23£ or 28	ai Director	10e. Street and Number 615 CHESTNUT AVENUE	Code 21204	10g. (U. S. A	•
DESIGNACE, IMBRYISHE 2 L2 13-0030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avent, it a Mudical Exercities must be multified at	ted by Funerai	1 Never Married 2 Married 1 Yes XX No If Yes, Give Year or Dates: 15. Decedent's Education 16a. Decedent's Usua	d Occupation	16b.	14. Race - Americ Black, White, Specify: Wh	etc.
filed within 7 Hygiene. other than "rent, If a Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+) HOU	rk done during most of work te retired) SEWIFE	ing	OWN HOM	1E
Maryland 21213-UU36 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 is marked other than "natural", or traumatic avent, it a Madical Exerci	To Be	17. Father's Name (First, Middle, Last) REV. WILLIAM O. SMITH	ANNA		NE	
i, Mar and 2 sh saith and n 27 is m		19a. Informant's Name/Relationship (Type, Print) WILLIAM C.TRIMBLE, JR. (ATTORNEY) 19b. Mailing Address 409 CHATT		VINGS MILL	y or Town, State, Zip S , MD . 211	Code)
rmit. Pages 1 ar partment of Hea portent: If item:		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ENTOMBM T DRUID RIDGE M	ther place)		Location - City or To	
Dant permit. Depart Import any inj	once.		d Address of Facility OWSON FUNERAL	. HOME, INC	1050 YO TOWSON,	RK ROAD MD.21204
Physicia /Medica Examine	al	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a			·	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
the death certiful the attending the attending ched for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pr 4 ☐ Pregnant at time of death 5 ☐ Other (sp			23d. Date of delive Month	ry Day Year
quires that n signed build be deta	b	Part II. Other significant conditions contributing to death but not resulting in the underlying contributions	ause given in Part I.		o use contribute to th	
	Completed			24a. Was an autopsy performed?	prior to con death?	osy findings available opletion of cause of
ysician: The ysician: The is certificate his director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	1	me 5 Residence	0 Dother (0	
5 £ 5 6	ation: T			28d. Describe how in)
To the Hospital or Attanding Physician: To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	, office	28f. Location (Street a City or Town, Sta		Route Number,
To the Hospital or within 24 hours after To the Funeral Dir	Medical (29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred a control of the basis of examination and/or investigation, and manner stated.	in my opinion, death occurr	ed at the time, date a	nd place, and due to	the cause(s)
Toti withi Toti	M	29b. Signature and title of certifier Mhyphy Ally My D	License number	29d. D	Date signed (Month, I	Day, Year) 007
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 1290 32. Sgistrar's Signatur 131. Date filed (Month, Day, Year)	ales St. o	falts .	N 212	dk
S Regis	tate strar	31. Date filed (Month, Day, Year) MAY 1 8 2907 32. Sgistrar's Signatur				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-03656 State of Maryland / Department of Health and Mental Hygiene Walter Brenton Smith 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 12, 2007 Walter Brenton Smith 2312 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore County Brickstore Rd. & Beckleysville Rd. Upperco If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** reign Country) Maryland Months Days Hours Min. 02/06/1964 Director 216 74 2689 43 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 X No Carroll Hampstead 23a or 28a-f show notified at once. Maryland the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21074 U.S.A. 1517 Brodbeck Road Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with it
Department of Health and Mental Hygiene.
Theportant: If item 27 is marked other than "natural", or items 23a
injury or other traumatic event, the Medical Examiner must be not 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Married Yes White 4 XDivorced Yes 2 X No specify: Specify. If Yes. Give Year Widowed \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Contractor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor Tate John Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 44 Thomas Avenue Lucille Smith / sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 5/18/2007 Glen Burnie, Maryland Glen Haven Mem. Park 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signal to of Funefal Service Licensee Gonce Funeral Service, Marvland 21 Baltimore. ghway 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ö φ Yes 2 ✔ No 3 Probably 4 ۵. Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has t performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: of Vital 25. Was case referred to medical Be examiner? Hospital: 1 Other ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 this 1 V Yes No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27, Manner of Death Certification: Motorcycle driver struck FOUND: Division Natural Yes 2 V No Pending within 24 hours after death. Director: d in by the May 12, 2007 2258 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Brickstore Rd. & Beckleysville Rd., Upperco, Md determined (Specify) Major Road / Highway Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

9,0

State 31. Date filed (Month, Day, Year)
Registrar

winter

Margarita Korell MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

docate)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 13, 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland			nd Menta	l Hygien	3 n n 7	16195
			Registrar 1. Decedent's Name (First, Middle, Las.	()	Certificati	e of Death	2. Dat	Reg. No	5-001	3. Time of Death
П	Physici /Medic		Florence	Terrell			M° C	nth Da	∂∞7	1:02 A M
	Examin		Facility Name (If not institution, give Greater Laure)	1	4b. City,	Town, or Location of		1	County of Death	n Deorge's
	Funeral Director		5. Social Security Number 6. Se 085-22-4293	7. Age (In yrs. II	ast birthday) If Under Months	1 Year If Under 24 Days Hours	Min. 8. Dat	e of Birth inth, Day, Year,	9. Birth Cou	place (State or Foreign Intry)
	Maryland I-f ehow	tor	10a. State 10b. County	-	Town or Location					10d. Inside City Limits 1 ☐ Yes 2 📉 no
	h with the 23a or 28s st be not	Funeral Director	100. Street and Number 1909 Shenand	oah Road	10f. Zip	43607		10g. Ci	tizen of What Cou	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show may injury or other traumatic event. The Medical Examinar must be notified at ance.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Deced	dent of Hispanic Original Communication of Hispanic Original Communication of the Hispanic Origi	n? (Specify Ye Puerto Aican, i	s or No- etc.)	14. Race - Ameri Black, White Specify: 13	
21215-0036	e filed within 72 hc al Hygiene. I other then "natur vent, the Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	16a. Decedent's Usua (Give kind of wo. life. po NOT us	rk done during most o	of working	16b. F	Kind of Business/In	o M
Maryland 2	should be filed nd Mental Hygi marked other Imatic event, I	To Be C	17, Father's Name (First, Middle, Last)	ner	70.0100.		s Name (First,	Middle, Maidei		
	1 and 2 sh Health and Sem 27 le m		Francine Terrell-W	lilcher (Daughter)	19b. Mailing Admers	Inetto C		Mantou	107	20874
Baltimore,	Pages 1 ment of He ent: If iter ury or oth		20a. Method of Disposition 1	Removal from State C	lace of Disposition (Namerery, crematory or o	ther place)	10/200	07 B	ocation - City or T	own, State
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	Preese	22. Na he an 515 173	d Address of Faculty	reene	Funera Balton	D Servi	29
	Physician		23a. Part1. Enter the isease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death ne cause on each line.	Do not enter the mod	1				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or as a consequ	lence of):	7, (6)	J	roma	7	
4	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):					
8760,	icete be executed physicien and s the burial-transit	ical Exe	resulting in death) Last	Due to (or as a consequent	ience of);					
Вох 6	To the Hospitel or Attending Physician: The law requires that the death certitice within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ectopic pr			- 9	23d. Date of deliv	rery Day Year
P. O.	that the ed by th detache	/ Phys	9 ☐ Unknows Part II. Other significant conditions co	9□ Unknown 	ulting in the underlying c	ause given in Part I.	23	e. Did tobacco	use contribute to	the cause of death?
ords,	equires en sign ould be	ted by	Hypertension	m				1 ☐ Yes 2	□No 3□Pro	bably 4 Unknown
Division of Vital Records,	n: The law i licete hes bu r, page 2 sh	Completed					1	a. Was an autopsy performed? Yes 2 No	prior to co	opsy findings available ompletion of cause of 21 No
Ĭ.	ysician is certii directo	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 □ DC	-	of Death (Chec		6 □Other (Speci	(v)
ion o	nding Ph ath. r: Atter th		27. Manner of D ath Natural 5 Pending Accident investigation			8c. Injury at Work?	28d. De	scribe how inju		
Divis	To the Hospitel or Attending within 24 hours atter death. To the Funeral Director: Attercompletely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory	r, office		ation (Street all or Town, State	nd Number or Rur e)	al Route Number,
	n 24 hour te Funer	edicai (29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	wledge, death occurred ion and/or investigation,	at the time, date and , in my opinion, death	place, and due occurred at th	to the cause(s e time, date an	and manner as a d place, and due t	stated. to the cause(s)
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7	0		30. Name and address of a reen who c	ompleted cause of death (Item		0532			1110	/
	,		Davyylu Hill 31. ate filed (Mont Day, Year)	3635 B	23a) (Type, Print)	e Ave	Lau	rel n	10 20	707
	Sta Registr	Control I	MAY 1 8 2007	May in M.	ure					

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The state of the s		48	a. Facility Name (If not institution, give stre							
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So Fard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Pancreatic Cancer	arked atic e	2 _			10h Mai	ling Addrage /Street				, Zip Code)
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Pancreatic Cancer (Final disease or conditions contributed to the cause of death of the contribution of death of the cause of death	Q E # 9	1	22 Part Enter the disease or complic	ations that caused the deat	h. Do not e					Approximate
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, DO Montgomery Hospice Rockville, MD 20855	within to the comple	Mec	29b. Signature and title of certifier	- 7.11		2.4		2		
Cynthia M. Williams, Do Frontegomer, nospite 1	6		and Address of person who of	ompleted cause of death (Ite	00-\ /Tu	me Drint)				
State 31. Date illed with 17, 497, cean 0.07		to-	Cynthia M. Will 31. Date filed (Month, Day, Year)				Obpice			

DHMH 17 Rev 1/2001

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 Physician 17, 2:10 A M Howard Milton Wheeler May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Baltimore Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 11, 1913 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1**X** M 2□ F Yrs 215-09-7216 93 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21286 915 Cromwell Bridge Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐XNo White Specify: Specify: à 3K Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government -Elementary/Secondary (0-12) College (1-4or 5+) 12 Baltimore City Engineer 12 should be filed whand mental Hygiel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic ev Harmon Wheeler Barbara Fischer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 915 Cromwell Bridge Road, Towson, MD 21286 Wendy J. Savelle, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/18/2007 West Arundel Crematory Obernton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fu Jeral Service Licenses 22. Name and Address of Facility Brian T. Chisholm Funeral Services of M01113 Dulaney Valley, P.A. 200 E. Padonia Road, Timonium, MD 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Schemic Cardionyopur **Physician** months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Division or Vital Records, P.O. Box 68760, Hospital or To the I within 2.

				1 Yes 2	My No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)	_
1 ☐ Yes 3 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 ☐ DC	OA Other: 4 Nursing H	Home 5 ☐ Residence €	Stother (Specify) No spice
27. Manner of Death 1)⊠ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	ne, farm, street, factor	y, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	ysician: To the best of my know niner: On the basis of examinati				

29b. Signature and title of certifier

29c. License number 8303 29d. Date signed (Month, Day, Year) May

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles m

and manner stated

St Ponson, no 21204 601 31. Date filed (Month, Day, Year)

State Registrar

3

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Certification: To

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year Martin F. Weedon Wa 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. agnes Hospita TIMORE 1 Year | If Under 24 Hrs. n/a 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1**⊠** M 2□ F Director 218-03-7390 86 1/11/21 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at Director 1 ☐ Yes 2 No Baltimore Μđ Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or Funeral 21207 USA 2012 Russell Avenue traumatic event, the Medical Examiner must permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or Health any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 ☐ Widowed 4 M Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 0 Transmission Mechanic A. D. Anderson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ John Lewis Weedon, Jr. Mary Theresa Rodgers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, Md. 21043 Mrs. Audrey Tutko / Daughter 4930 Eastwood Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of Balland Brandow at Market Objectory 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State @ Loudon Park 5/18/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licens 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h. art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4therosclerotic Physician +corr(UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed sician and burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Pulmonary ructive 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 **X** No 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 2 EA/Outpatient 3 DOA 1 Inpatient Certification: To 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. 28d. Describe how injury occurred Injury at Work? or Attending 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Needon, Martin Division or Vital

State

29b. Signature and title

31. Date filed (Month.

e and address of

Homes

n who completed cause of death (Item 23a) (Type, Print)

JR, MO

strar's Signature

29d. Date signed (Month, Day, Year)

Caral Walton

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, E.

		Please	Type or Print in E State of Marylan				-		_		
		1 - For State Registrar	State of Marylan		rtificate of		Mental Hy	ygiene Reg. No	21107	161	99
Physici	an	Decedent's Name (First, Middle, Las	1661	i			2. Date of D Month			3. Time of	Death
/Medic	al	4a. Facility Name (If not institution, give	Wal-	100	4h Cihi Tour	and another of Danie	May	14	2007	8:00	A. M
Examir	ier	10824 Sandringham	ŕ		Cockeys	or Location of Deal	ın		County of Dea 31t.imore	m e County	J
Funeral		Social Security Number 6. S	7. Age (In yrs.	**	If Under 1 Year Months Days					thplace (State of	
Director		224-38-2956 19 Usual Residence of Decedent	ZM 2UF 74	Yrs.			Apr.1	7, 19		chriond.	
ryland how	_	10a. State 10b. County		y, Town or Lo	cation					10d. Inside Cit	ty Limits
he Ma	ecto		re County Coc	keysvi						1 Tes	2 🔼 No
ith with the Marylan 23a or 28a-f ehow	Funeral Director	10e. Street and Number 10824 Sandringham	Road		10f. Zip Code 21030			_	izen of What Co .ed Stat	•	
after death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H f Yes, specify Cubi	Hispanic Origin? (S	Specify Yes or N		14. Race - Ame	erican Indian,	
rs afte	by Fu	1 ☐ Never Married 2/ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Yes 2√2√No	Specify:	to rican, etc.)		Black, White	hite	
within 72 hours after death with the Maryland ene. Then "naturel", or iteme 23a or 28a-f ehow he shouldel Exacultier most be notified at	ted t	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occup	pation		16b. K	ind of Business		
ne.	Completed	(Specify only highest grad	College (1-4or 5+)	life. L	kind of work done OO NOT use retired	d)	rking			,	
filed v Hygie other t	O S a	1.2 17. Father's Name (First, Middle, Last)	4	Mech	anical Er	ngineer 18. Mother's Nar	ne (First. Middle		gineeri Sumamel	ng	
uld be Jental rked c	To Be	Lawrence Ellis Wal	.ton				e Gilman		<i>Surramo</i>		
2 sho and h is ma	13	19a. Informant's Name/Relationship (T			g Address (Street						
1 and Health em 27 ther ti		Mrs. Nancy Walton 20a. Method of Disposition			4 Sandrin		ad, Cock		ille, M		21030
Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			sition (Name of natory or other place neral Cha						vland
permit. Pages 1 and 2 should be itied within 72 hours Department of Health and Mental Hygiene Important: if Item 21 is marked other then "naturat," eny injury or other traumetic event, the Modical Exa	1	21. Signature of Funeral Service Licens		22	Name and Addre	ss of Facility					
#QE # 9		Jam J.	Jem	23	aceful Al 25 York F	Road Time	onium. M	arvl	and 210	93	
Dhysisian		23a. Part1. Enter the disease or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	1. Do not ente	or the mode of dying	ng, such as cardia	or respiratory a	irrest,		Approximate Interval Betw Onset and D	veen leath
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ience of):	CUP	IF (UB.	R			-141	2
Examiner		Sequentially list conditions,	b								
uted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
e executed ien and urial-transit	Exa	resulting in death) Last Due to (or as a consequence of):									
The law requires that the death certificate be exate has been signed by the attending physicien page 2 should be detached for use es the buria	dicai	d									
certifi nding p	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnal	ncy					23d. Date of deli		
death	sicial	in the past 12 months? 1 ☐ Yes 2 X No	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		Ectopic pregnancy Other (specify)			1	Month		ear
hat the de od by the a detached		9 ☐ Unknown Part II. Other significant conditions co		Iting in the un	doshina assas alis	en in Book!	22- 514				
uires that n signed t	ا عد		minotally to doubt but not resu	ining in the un	derrying cause givi	en in Paitti.		Yes 2[the cause of de	nknown
aw require is been si 2 should t	plete						24a. Was	an	24b. Were au	topsy findings a	vailable
The lav	Completed					-	auto perfo 1 ☐ Yes	psy ormed? 2 No	death?	completion of ca 2 ☐ No	use ol
ysiclan: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	lospital:		occ post Other	26. Place of Dea	. /	one)			
둔 도교	<u>ان</u>	27. Manner of Death	1 L Inpatient 2 L E	R/Outpatient 28b. Time of	28c. Injun	4 ∐ Nursing H ∕at	ome 5 Resi 28d. Describe		Other (Spec	ufy)	
eath. or: After the funer	catlo	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day 1 Gar)	Injury	M 1 🗆	Yes 2 □ No					
after d Direct Direct	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (City or To	Street and wn, State,	Number or Ru	ral Route Numb	er,
		29a. Certifier 1 Certifying Phys. (Check of 2 Medical Exami	sician: To the best of my know	vledge, death	occurred at the tim	ne, date and place	, and due to the	cause(s)	and manner as	stated.	
To the H within 24 To the Fi complete	Medical		ner: On the basis of examinati and manner stated.	on and/or inve			rred at the time,				
T v i v		29b. Signature and title of certifier	f thus in	1	29c. License	651L	,	29d. Date	signed (Month	, Day, Year)	
141		NV e and address of person who g	mpleted gause of death (Ite	23a) (T <u>y a</u> P					1 17	+	
114,		HICHURCY CIT	1115119 15	75	CKUr	-Pr. Si	IITE S	ンノ	lows	on M	D
Stat Registra	G	31. Date filed (Month, Day, Year)	32. R + strar's Sign in	2000	W						
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07-03742 Eddie Lee Wheele	er. J	Please Type of State	or Print in Black Ind of Maryland / Depar	elible In	k. Ensure A Health and M	All Copies Mental Hyg	Are Le	.00%	007 162
200.0 200 111.00	1.	For State		ficate of		, ,		Reg. No.	00/ 102
Physician Me-" al Examin	n/ 1	egistrar Decedent's Name (First, Middle,La	wheeler	Jr.			Date of Dea Month May 16, 2	ath Day Year 2007	3. Time of Death 1735 hrs
(4	la. Facility Name (if not institution, gi Upper Chesapeake Medic		4	o. City, Town, or Loca Belair	ation of Death		4c. County of I Harford	Death
Funeral Director	ć	6. Social Security Number 6. S		t birthday) 24 Yrs.		Hours Min.	8. Date of B	000	9. Birthplace (State or Foreign TOUSON, Country)
nd show any ace.		Usual Residence of Decedent 10a. State 10b. County 10b. Hourf	ord 5.	own or Location	1				10d. Inside City Limits 1 Yes 2 No
he Maryk 1 or 28a-f iffed at o	Director	3349 Adv A	Rd.		10f. Zip Code 21/15	4		10g. Citizen of What	t Country?
death with or items 23.	ᇹ	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year	If Ye	Decedent of Hispan is, specify Cuban, Me Yes 2 No sp	exican, Puerto Ri		White,	American Indian, Black, etc. White
ours afte	함	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:	16a. Decedent	's Usual Occupation ost of working life. DC	(Give kind of wo	rk done	16b. Kind of Busi	
11215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "natural"; event, the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		borer				Pipeline
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Las	Wheeler S		18.	Linds	~ . /	, Maiden Surname)	
e, MD 21215-003 I and 2 should be filed withi Health and Mental Hygiene 'Tiem 27 is marked other the r traumatic event, the Meso		19a. Informant's Name/Relationship	00.7	19b. Mailing	Address (Street an				State, Zip Code)
e, MD 2 1 and 2 shoul Health and N irem 27 is n	ŀ	20a. Method of Disposition		lace of Dispos ematory or oth	tion (Name of cemete	ery,	Date	20c. Location - C	City or Town, State
MOF Pages ent of unt: If		1 Burial 2 Cremation 3 4 Donation 5 Other Specific	fy: Removal norm state	ans Fu	neral Ita		8/07		Hill, MD
Balti permit. Departm Importa		21. Signature of Funeral Service Lice	ensee Nu JMTV	22. N Se	ame and Address of	Facility das	West	eral chaj Dr forstli	oel & Creman
Physician	7	23a. Part I. Enter the disease, or confailure. List only one cause on	hpl/cations that ca sed he death.	Do not enter the	ne mode of dying, suc	ch as cardiac or	respiratory a		
Medical _xaminer		or condition resulting in death)	Due to (or as a consequence of):					Death
	miner	if any, leading to immediate	b):					
cuted and transit	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of d.):					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executinin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial	sician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of deal	2 Fe	tal death 3 her (Specify)	Ectopic pregnar	ncy	23d. Date of o	delivery Day Year
P.O. Bees that the defigned by the	된	Part II. Other significant condition	Control of the second second	sulting in the	underlying cause give	en in Part I.			oute to the cause of death?
S, P. Juires th	ted by						24a. Wa	as an 24b. W	Probably 4 Unknown Vere autopsy findings available
Cord	Completed	/ 						rformed? d	rior to completion of cause of eath? Yes 2 No
I Re n: The rtificate or, pag	S	25. Was case referred to medical				f Death (Check o	-	3 2 110	7.00
Vita hysicia this ce	e o	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2				g Home 5	Residence 6	Other:
n of iding P. th. : After e funera	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) May 16, 2007	28b. Time of 1705 hrs				to auto collision	
Division of Vital Records, tal or Attending Physician: The law requirers after death. "In Director: After this certificate has been sited in by the funeral director, page 2 should be a possible or the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director.	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	ation 28e. Place of Injury - At ho				or Tour	Ctoto)	er or Rural Route Number, City un Bridge, Belair, MD
he Hospi in 24 hou he Funer pletely fil		29a. Certifier 1 Certifying Phys	sician: To the best of my knowled	ge, death occu	rred at the time, date	e and place, and death occurred a	due to the c	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
To the within To the comp	Medical	29b. Signature and title of certified	and manner stated	1	29c. License i	number			ed (Month, Day, Year)
,0		30. Name and address of person w			nn Street, Baltin	nore MD 21	201		
\\		Susan Hogan MD. As	sistant Medical Examiner	ппе	iii Olicel, Daillii	11010, IVID Z 1.			

32. Registrar's Signature

beals

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 17, Day 007 **Physician** 12:10A M Eileen Westervelt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 8703 Littlewood Road 8. Date of Birth (Month, Day, Year) May 12,1926 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 130-16-6372 81 Months Hours Min. New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Director MD Glen Arm 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21057 12002 Somerset Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 Ϊ No Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4or 5+) Elementary/Secondary (0-12) Food Service Board of Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Taylor Oscar Ostrander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen J.Westervelt-son 12002 Somerset Avenue-Glen Arm, Maryland 21057 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Parkwood Cemetery 1 □ Purial 2 □ Cremation 3 □ Removal from State May 21,2007 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) cHAPEL 8800 Harford Road SERVICES Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of) Examiner The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as led by the attendin detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b: Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2₽No 1□ Yes Hospital or Attending Physician; 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Son Share Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this filled in by the funeral 27. Manny r of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident Director; 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Funeral 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

State Registrar 29b. Signature a

31. Date filed (Month, Day,

Day, Year)

DHMH 17 Rev 1/2001

Registrar

07-03149 Raymond Gary 2	Zuhr	Ple rowski .tr		or Print in B						gible.		
		1- For State Registrar		e of Maryland		ate of Dea		io ivientai n	Re	eg. No.	200	7 620
Physicia Medical Examin		1. Decedent's Nam	d Gary	Zubrow		Jr.			2. Date of Deat Month April 23, 2	Day 007	Year	3. Time of Death 1703 hrs
<i>!</i>		2556 Toddy		jive street and number)		dville	r Location of Deati		Do	ounty of Death rchester	
Funeral Director		5. Social Security N 217 - 25 -	-8432 _{1[}	Sex 7. A	ge (In yrs. last birt	hday) If Ur Yrs. Mor	nder 1 Yea		s. 8. Date of Bird	2,19	988 Foreig Cou	hplace (State or n Maryland untry)
v any	ŀ		10b. County	•	10c. City, Town		1.1					10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.	ş	Md .	enco	imore	15.	Dunda:	L K Zip Code		110	0a. Citizer	n of What Cour	1 Yes 2 X No
h the Ma 3a or 28	Director	2600 Pa	age Dri	ve			212	22			USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Marrie	ed 2 Marrie	12. Was Deceden Armed Forces 1 Yes 2				spanic Origin? (S n, Mexican, Puerto		- 14	Race - Ameri White, etc.	can Indian, Black,
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5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name	Oth (First, Middle, Las	st)	1	Labore	r 	18.Mother's Nam	e (First, Middle, N	HOD Maiden Su		rovement
21218 buld be fil. Mental H marked cevent, t	æ	Raymono		Zubrowsk		n Mailing Addre	es /Stra	Debora	h Topa		or Town State	Zin Codo)
MD 2 d 2 shou of the and N n 27 is r		Mr&Mrs H	Raymond	Zubrows	ki,Sr 2	2600 Pa	age	Drive E	Baltimo	re,	Md. 2	1222
Nore, ages 1 an at of Hea t: If ite			Cremation 3	Removal from S	tate cremat	of Disposition (Nory or other place	ce)		Date 9 - 2 0 0 7		cation - City or	Town, State , Maryland
Baltimore, permit. Pages I an Department of He. Important: If ite	ł	4 Donation 5 21. Signature of Fu			30.31	22. Name a	nd Addres	s of Facilit KaC	zorows	ki l	unera	I Home, PA
ய திற்கிக் Physician	-	23a. Part I. Enter th	ne wsease, or con	mplications that caused	the death. Do no							d . 21222 Approximate Interval
/Medical xaminer	i	failure. List on Immediate Cause (or condition resulting		a. No Identifiable		use of Deat	h					Between Onset and Death
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P.O. Es that the ces that the cigned by the be detached	by Phy	Part II. Other signi	ficant conditions	s contributing to dea	th but not resultin	g in the underlyi	ing cause	given in Part I.				the cause of death?
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'Vital Physician: r this certifi	To Be	examiner?	2 No			utpatient 3	DOA	Other Nursi	ng Home 5		e 6 🗸 Other	: Scene
Sion of Attending Pheath. Extor: After Iny the funeral	tion:	27. Manner of Deat 1 Natural	5 Pending		Year) FOL	Time of Injury JND:	20 fakt	ry at Work? Out Yes 2 No	28d. Describe I Unknown	how injury	occurred	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	Certification:	2 Accident3 Suicide4 Homicide	6 Could no determin	ot be 28e. Place of I	njury - At home, fa) hrs arm, street, facto	ory, office	building, etc.	28f. Location (5 or Town, S Unknown, ,		Number or Ru	ral Route Number, City
D To the Hospital within 24 hours. To the Funeral	Medical (ician: To the best of ner:On the basis of exa								
To To Cor	Me	29b. Signature and	title of certifier	and manner stated	۸ ۸ ۰	2		se number			ite signed (Mor	nth, Day, Year)
	-	30. Name and addr	ess of person who	o completed cause of	death (Item 23a)	vs	U.C.	.M.E.		April 2	25, 2007	
3		Patricia Aro	nica-Pollak M	ID. Assistant I	Medical Exam	6	Penn S	treet, Baltimo	re, MD 2120	1		
Sta Regist	ate rar	31. Date filed (Mont	182007	32. Registra	ar's Signature							

Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner Renaissance Gardens at Oak Crest 6. Sex 5. Social Security Number **Funeral** 1 X M 2 □ F 95 097-05-1585 Director Usual Residence of Decedent 10b. County la or 28a-f show t be notified at Director Maryland Baltimore 10e. Street and Number 8810 Walther Blvd. #1313 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, the M dical Examiner must t once. Funeral Expired State? gradom 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2K Married 3altimore, Maryland 21215-0036 2 Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Paul Alfred Zehl ဥ 19a. Informant's Name/Relationship (Type. Print) Emma A. Zehl / Wife 20a. Method of Disposition 1 ☑ Burial 2 □Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatu of Funeral Service Licensee Physician /Medical

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Richard Alfred ZEhl, Sr. 9:20 P. 2007 May 12, 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Sept. 21, 1911 Germany 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Baltimore 10g. Citizen of What Country? 10f. Zip Code 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No Specify: White Specify: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Furniture Designer Carpentry 18. Mother's Name (First, Middle, Maiden Surname) Pauline Stoeffler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1313 8810 Walther Blvd. Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May Ito. 2007 Gardens of Faith Cem. Rosedale, MD 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A.
421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hemoptysis, dyspnea, weight loss, hematuria 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No prostate Cancer h/o blader cancer and 1∐ Yes ANO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√√No 2 ER/Outpatient 3 DOA 28h. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier P61785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Box 68760, physician at the burial attending pl for use as t Division or Vital Records, P.O. signed by the has been signed as 2 should b After this certificate har funeral director, page within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Examiner

Physician/Medical

Completed by

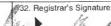
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Medical Certification: To

6

Registrar

Efosha Dixorno 8800 Walther Boulev and Parhville, MD 21234 31. Date filed (Month, Day, Year) State



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** May 14, 2007 1543 hours Zajicek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🕅 F 336-12-0599 84 Director May 2, 1923 Illinois Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 404 Barnside Street 20850 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Snecity. Specify: ģ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Thermos Vasiliki Alexander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tatlock La., Cornwall, P.E.I., Canada COA 1HO Dale Zajicek (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 5/19/07 Forest Park, IL 22. Name and Address of Facility Pendersen-Ryberg Mortuary 21. Signa ure of F neral Service Licensee 435 N. York Rd., Donnes Elmhurst, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary Embolism Hours /Medical Due to (or as a consequence of): Examiner Deep Vein Thrombosis Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Left Hip Arthroplasty Months Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12-months? 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 X ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours af To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

0,

Ann Zalicek

Peter G. Harman, M.D. 31. Date filed (Month, Day, Year)

29b. Signature, and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5530 Wisconsin Ave., Chevy Chase, MD 20815

29d. Date signed (Month, Day, Year)

May 15, 2007

29c. License number

D32033

State Reğistrar

and manner stated.

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Maryland	hand hand risum raum		19a. Informant's N				1420	0 N Stree	et, N.W. D.C. 200	ral Route Numbe #308	er, City or	Town, State, Ziţ	o Code)
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Baltimore,	Pages nent of nt: If i			☐ Cremation 3 5 ☐ Other (Spe	3 □ Removal from State ecify)			Cemetery	5/4/	2007	Suit	land, M	d.
<u> </u>	permit. Pages 1 and 2 should be liled within 72 hours after death with the marylan Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Li	censee	,	22	Name and Addre	s Funera	1 Home.	Inc.		
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DIVISION OF	r Atter er deal rector by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Place of In	jury - At hor tc. (Specify	me, farm, str	reet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rui	ral Route Number,
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	within to the property of the	Me	29b. Signature an	d title of certifier	10. 2A	1-1.	0	29c. Licen	se number	2	29d. Date	signed (Month	Day, Year)
)	(m)		30 Name and add	JICA tress of parson ::	/ho completed cause of	death (Item	23a) (Type	Print	7040	/		0 171	er conna
1	-0		OKIK	Twon,	MID.	103	13	Georg	Fin Ave	inve#	209	1 17	20902
	Sta Registi		31. Date filed (Mo	onth, Day, Year) 4 2007	32. Regist	rar's Signat	and)						·

	Funeral Director	¥"-
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

		Registrar			Ce	ertificate of	Death			Reg. No.	-001	10101
V-		1. Decedent's Name (First, Middle	e, Last)						2. Date of De		.,	3. Time of Death
Physicia		William August	ic Alechii	re					Month April	24. Day	2007	6:00 P M
/Medic		4a. Facility Name (If not institution				4b. City, Town, o	or Location of F		прити		County of Dea	
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mar	-	19a. Informant's Name/Relations			19b. Mai	ling Address (Street	and Number	or Rurai	Route Numb	er, City o	r Town, State,	Zip Code)
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oy th	fic	3 Suicide 6 Could 4 Homicide detern	ningd 200. Flat	e of injury - At ho	me, farm, s	treet, factory, office		2				ural Route Number,
Dir.	Certification:	4 🗆 Homicide	Dull	ding, etc. (Specif	y)				City or To	wii, State	7)	
ours ille fille		29a. Certifier 14 Certifyi	ng Physician: To the	ne best of my kno	wledge, dea	ath occurred at the	time, date and	place, a	and due to the	cause(s)	and manner a	s stated.
within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medica one)	I Examiner: On the	basis of examina nner stated.	tion and/or	investigation, in my	opinion, death	n occurre	ed at the time	, date and	d place, and du	e to the cause(s)
Thin thin the maple	Mec	29b. Signature and title of certific		,,,,or stated,		29c. Licen	se number		T	29d. D.at	te signed (Mon	th. Day, Year)
₽ ₽ 8		200. Orginature and title or certific		1. (1							, 20,1 . 301,
Ì		Olamene	. 01,69	19980	nyn	D2807	79			4/25	/2007	
	_	30. Name and address of person	who completed car	use of death (Item	1 23a) (Type	e, Print)						
+10	1	Francine A. Hi	ggs-Shipm	an, M.D.	9200	Basil Co	urt Su	ite	200 La	argo,	MD 207	774
Sta	te	31. Date filed (Month, Day, Year) 32.	Do strar'a Signa	turo							
Registr	ar	MAY	0 3 2007	Clown	A.	Good						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					State	o Maryia	-			Death	мептат ну	Reg. No.	7	1620)8
	Physicia	n	Decedent's Name	e (First, Middle, L Eva	Last)	Lou	ise	A	lkire		2. Dete of De Month May 7.	Dey	Year	3. Time of De	
2000 0	/Medica Examine	_	4e Facility Name (II	not institution, g	rive street end nu					4b. City, Town, or			of Death	1545	FM
E.			Allegany	County	Nursing	& Reha	ab. Cent	cer		Cumber	land	Alle	gany		
	Funeral Director		5. Social Security N 229 – 05–32	206	Sex 1□M 2⊠F	7. A ge (In yi	s. lest birthday) Yrs.		der 1 Year ns Days	If Under 24 Hrs Hours Min.		th ey, Year) '1916		lace (State or F try) inia	oreign
	pur *	-	Usual Residence of 10a. State	Decedent 10b. County		100.4	City, Town or Lo	cation	-				14	0d. Inside City L	Limite
	r 28a-f show		MD	Allega	anv				rland					1 [X] Yes 2	
	28a	<u> </u>	10e. Street and Nun		J				Zip Code		1	10g. Citizen of V	Whet Coun	try?	
	th with	2	235 P	aca Str	eet					21502		U	SA		
020	led within 72 hours efter death with the Maryland lygiene. The "natural", or items 23a or 28a-f show the than "natural", or items 23a or 28a-f show the than Medical Examinar must be notified at	ny rune	11. Marital Status 1 ☐ Never Marric 3 ☑ Widowed		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2 ☑ No ve				lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rac Blac Specify	e - America ck, White, o /: Wh		
Maryland 21215-0020	within 72 hours inen "natural", e Medical Exe	mblered	(Speci		Education rede completed) College (1-4or 5+)		kind of t DO NOT	work done use retired	eation during most of wo d)	rking	16b. Kind of Bu	usiness/Ind		
2	Hygie Ther i	3	12 17. Father's Name (First Middle I a	et)		Sea	.msti	cess	18 Mother's Na	me (First Middle	Facto Maiden Suman	- /		
Jan	Mental H Mental H arked oth atic even	6	John	i iist, iiiiddie, Lat	Will	iam	Go	rdor	า	Katie	Ar		Keato	n	
ary	shour Mind Mind Mind Mind Mind Mind Mind Mind		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailir	ng Addre	ess (Street	and Number or R	urel Route Numb	er, City or Town,	State, Zip	Code)	
	alth e		Paul G.	Deahl /	Nephew		Rfd	#1 B	3ox 2	3, Wiley	Ford, W	IV 2676	7		
Baltimore,	permit. Pages 1 end 2 should be filed within 7. Department of Health end Mental Hygiene. Important: if item 27 is marked other than "ni any injury or other traumatic event, the MedianGe.	-			□Removal from	State	Place of Dispo cemetery, cres	sition (A natory o	leme of r other plac	rk 05/1	Date	20c. Location -			
Balti	permit. Departmine imports any injuine. Dece.		21. Signature of Fur	neral Service Lice	ensee		22	. Name	and Addre	ss of Facility Ac	lams Fam	ily Fune	ral I		. A .
		1	23a. Part1. Enter th shock, or hear	e disease, or con t failure. List onl	mplications that of yone cause on e	aused the de ach line.	ath. Do not ente	er the m	ode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	en
No.	Physician /Medical Examiner		Immediate Cause (F disease or conditior resulting in death)	Final	a. Cox	<u>onam</u> Due td	A v	ter uence c	7	Discar	4			Onset and Dea	ath f
Box 68760,	The law requires that the death certificate be executed lete has been signed by the attending physician and page 2 should be deteched for use as the buriel-transit		Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or I hat initiated events resulting in death) L	ditions, mediate lying njury	c		(or as a consequence of as a consequence of as a consequence of as a consequence of a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a conse								
	death e atte	-	Part II. Other signific	cent conditions	contributing to de	eath but not re	sulting in the ur	nderlying	cause giv	en in Part I.	23b. Did	tobecco use cor	ntribute to	the ceuse of d	deeth?
% P.O	v requires that the death cert been signed by the attendin should be deteched for use										10	Yes 2 No	3 ☐ Prob	ebly 4⊡Unl	known
Records,	The law require sete has been sign page 2 should t	-		-								an autopsy med?	ava	re autopsy findi ilable prior to npletion of ceus leath?	
<u>~</u>	The ete h										10	res 200 No	1 🗆	Yes 2□ No)
119	hysician: The law his certificate has to director, page 2 s	2	25. Was case referre examiner?	ed to medical	11				0		ath (Check only o	ne)			
Division of Vital	Attending Physician: or death. actor: After this certific by the funeral director,	2	1 ☐ Yes 2 ☐ ↑ 7. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of (Mont	npatient 2 (of Injury h, Day Year)	28b. Time of Injury	t 3□ [28c. Injun World	4 Jarwursing H		dence 6 □Othe now injury occurr		1	
Divisi	To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral di Madical Certification: Tr		3 Suicide 4 Homicide	6 Could not l determined	be 28e. Place	of Injury - At ng, etc. (Spec	home, farm, stre	et, facto	ory, office		28f. Location (3 City or Tou	Street and Numb vn, State)	er or Rural	Route Number	r,
	ne Hospita n 24 hours ne Funera pletely fille	1	29a. Certifier (Check only one)	Certifying P	hysicien: To the miner: On the ba and mann	isis of examin	owledge, death ation and/or inv	occurre	d at the tim on, in my o	ne, date and place pinion, death occu	, and due to the rred et the time,	cause(s) and ma date and place, a	nner as sta and due to	ited. the cause(s)	
	vithir vithir To th		9b. Signature and t	itle of certifier				2	9c. Licens	e number		29d. Date signed	(Month, E	ay, Yeer)	
	3			1 pm	hand				000	33280		May	8 2	007	
f	20 1 1	3	0. Name end eddre		completed caus Gupta, N	,		-	Venue	, Cumber	land Mi	21502)		
	アルシ State	3	11. Date filed (Month			egistrar's Sign	nature		venue	, camber	rand, m	21702			
	Registrar		MAY	0 8 200	1	no lo	K food	Al.							

DHMH 16 Rev 6/95

			1 - State Registrar		Cei	rtificate of	Death	Re	eg. No. 2 U	0/ 1620
	Physicia	an	Decedent's Name (First, Middle, Lateral		D			2. Date of Deat Month	Day '	3. Time of Death
	/Medic	ai	William	Α.	Barnstri		- Lagation of Dogth	Apr 29	4c. County o	7:50am M
Ĺ	Examin	er	4a. Facility Name (If not institution, giv Beverly Living Ce			Cumbe	er Location of Death		Allega	
-	Funeral Director		5. Social Security Number 6. S 215-14-6887 Usual Residence of Decedent	ex 7. Age (I. 8	n yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 22,	^{Year)} 1923	9. Birthplace (State or Foreign County)
	/land low at		10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits
	a-f sh	ctor	MD Allega	any	Cum	nberland				1 X Yes 2 No
	th with the 23a or 28 ust be no	ral Director	10e. Street and Number 110 East Elder S	treet		10f. Zip Code	21502	10	og. Citizen of Wh	nat Country? SA
0030	be filed within 72 hours after death with the Maryland rital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Eve August Forces? 1 1 Yes 2 No If Yes, Give Year or Dates: V		Was Decedent of H If Yes, specity Cub 1 ☐ Yes 2☐ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		- American Indian, White, etc. White
0-017	ithin 72 hc ne. han "natul e Medi al	Completed	15. Decedent's English of the Composition of the Co	ducation ade co <i>mpleted)</i> College (1-4or 5+)	16a. Deced (Give life. I		pation during most of work d)	ing	16b. Kind of Bus	iness/Industry Im Company
and 2		Be	17. Father's Name (First, Middle, Last George W. Ba		Labo	i Gi	18. Mother's Name	 e (First, Middle, M (Norris) E	Maiden Surname)
Mary	nd 2 should lith and Men 27 Is marke r traumatic	To	19a. Informant's Name/Relationship (nter 19b. Mailir	ng Address (Street B Oregon		,		MD 21666
more,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	20b. Place of Dispo cemetery, crei Hillcrest Me	sition (Name of matory or other pla morial Park	ce)	Date 5/5/2007	20c. Location - C	erland MD
baltimor	permit. Pages Department of Important: If it any injury or once.		21. Signature of Fundran Service Lice	IIII	7 22		ள មប៉ាម៉ោង। Ho ginia Avenue		d, MD 2150)2
š	Physician /Medical		23a. Ant 1. Enter the disease, or con- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	Sichaer	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a c	Commence on.	alx a	ifer d	Decre		15 years
	p .±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):	0				
۲,	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):					
09/90	certificate be executed ding physician and ise as the burial-transit	Medical E		d						
O. Box o	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1□Live birth 2 [4□Pregnant at tim 9□Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date Mon	of delivery th Day Year
as, r.	requires that the death een signed by the atter rould be detached for u	þ	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob		bute to the cause of death?
Tecoras	The law requate has been bage 2 should	Completed						24a. Was a autops perforr	n 24b. W	fere autopsy findings available for to completion of cause of eath?
VITAL	in: Th	e Co	25. Was case referred to medical				26. Place of Deat	1□ Yes	No 1	□Yes 2□No
-	nysicia lis cert direct	To B	examiner? 1 ☐ Yes 2 2No	Hospitał: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth		ome 5 Reside		r (Specify)
o uo	th. : After the function		27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	Wo		28d. Describe ho		
DIVISION OF	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		- At home, farm, str Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural Route Number,
	ne Hospit n 24 hour ne Funer	edical (nysician: To the best of r miner: On the basis of ex and manner stated	camination and/or in					
	Mithi To t	Ž	29b. Signature and title of certifier	2 lour	MD	29c. Licens				(Month, Day, Year)
ļ	V		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)	-105	to 1	1/	30, 2007 unberland
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	0600 C	avung	VI GUL CHI	ur, co	Md 2/502
	Sta Registr		WAV 1 9 200	47	A Area	6 8				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician 29, 2007 4:40 P.M April Mary Elizabeth Barber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 1414 8th Street Glenarden 8. Date of Birth (Month, Day, Yea 2/2/1910 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 ₩ F 97 Maryland Director 578-30-1917 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Md. P.G. Glenarden 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 1414 8th Street U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1

✓ Never Married 2 Married l □ Yes 2 No f Yes, Give Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hairstyling permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hyglen. Important: If Item 27 is marked other the any injury or other traumatic event, the once. Beautician unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matilda Harper George W. Barber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 17023 Fairway View Lane, Upper Marlboro, Md. 20772 James L. Barber/Nephew 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/4/07 Resurrection Cem. Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility H.S. Washington & Sons Co. Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 aus 23a. Part1. Enter the diseste, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metasta **Physician** Carcinomo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 Yes 2 4 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 100 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Écertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Patricia G. annam 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

/Medical

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1-

To Be Completed by Funeral Director

Physician /Medical

Examiner

Funeral

Director

al Residence of Decedent State 10b. County ryland Prince Ge Street and Number 6413 Grendel Planarital Status I Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Edu (Specify only highest grace) Idementary/Secondary (0-12) 9th Father's Name (First, Middle, Last) Norman Russell	Gertrude Adella street and number) y Hospital x	## Ab. City, Town, or L Lan	Location of Death hham If Under 24 Hrs. 8 Hours Min. A 20 In panic Origin? (Special, Mexican, Puerto Rices) Specify: tion	Date of Birth (Month, Day, Year) Pril 23, 10g. Ci	County of Death Prince Geo 9. Birthplac Country 1919 Vi	e (State or Foreign Pginia Inside City Limits 1 ☑ Yes 2 ☐ No ?
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		b, Mailing Address (Street ar			or Town State Zin Co	nde)
a. Informant's Name/Relationship <i>(T</i>) inwood Norman Bro	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	413 Grendel P				oucy
. Method of Disposition	20b. Place of	of Disposition (Name of	Dat		ocation - City or Town	, State
1 Burial 2 □ Cremation 3 □ I	Removal from State	ery, crematory or other place	' i			
4 □ Donation 5 □ Other (Specify, Signature of Funeral Service Licens		view Cemetery 22. Name and Address	5/9/20 s of Facility W	07 R Watking	ichmond. V & Son Fine	irginia ral Home
Signature of Pulleral Service Little	2/1000	2700 North				rar none
a. Part1. Enter the disease, or comp	fications that caused the death. Do	not enter the mode of dying	, such as cardiac or	respiratory arrest,	A	pproximate iterval Between
shock, or heart failure. List only omediate Cause (Final	one cause on emiline.	L. (2)	eumon	•		nset and Death
ease or condition sulting in death)	a. Due to (or as a onsequence		EDCIPION			
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t initiated events ulting in death) Last	c Due to (or as a consequence	of):				
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FEMALE: b. Was decedent pregnant	23c. If yes, outcome pf pregnancy	t. 0		4	23d. Date of delivery	
in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3□Ectopic pregnancy 5□Other (specify)			Month Da	ay Year
9 Unknown				00- Biddahaaaa		acuse of death?
t II. Other significant conditions co	ontributing to death but not resulting	in the underlying cause give	n in Part I.	1 ☐ Yes	use contribute to the	ly 4 ∐Unknown
12000	SMU					
			-	24a. Was an autopsy performed?	24b. Were autops: prior to comp death?	y findings available letion of cause of
NAT-			00 Plane (D)	1□ Yes 2 N		□ No
Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1▶ Inpatient 2 □ ER/O	Othe	26. Place of Death		6 □Other (Specify)	
Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury		Bd. Describe how inju		
1 ■ Natural 5 □ Pending investigation			res 2 □ No			
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, the building, etc. (Specify)	arm, street, factory, office	28	If. Location (Street a	and Number or Rural F	Route Number,

State Registrar 30. Name and address of person of the second

29b. Signature and title of certifier

ess of person who completed cause of death (tem 29a) (Type, Print) 32. Registrar's Signature

29c. License number

SINDER SINDER

5660

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** April 28 2007 23:39 SARAH BELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Prince George's Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Yrs. 28, 1948 North Carolina 59 244-80-6835 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10h County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo Prince George's Clinton Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 United States 6005 Terrence Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AT & T (Private) 12th Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah White Is marked Melton Joseph Bryant ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6005 Terrence Drive, Clinton, Disposition (Name of Date 200 MD Robert G. Bell/Husband item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Grove Church 5/5/2007_ 22. Name and Address of Facility Stewart 4 □ Donation 5 □ Other (Specify) Riddick Grove Church Belvidere, NC 21. Signal re o Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 Oh ewon Kospira **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that the death certificate be executed that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): Box 68760. physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) P.0. the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death e Hospital or Attending P 24 hours after death. e Funeral Director: After t After 1 Certification: (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

CA B

State Registrar 31. Date filed (Month, Day, Year)

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May 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ^{Day} 2007 May 10:05 P M Bush Wayne Robert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) Days Months Hours 1√2 M 2 □ F 68 Wash., D.C. 578-50-1888 10-07-1938 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arundel Lothian 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20711 USA 17 Daniel Drive 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1957–65 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) painting painting contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Emory C. Robert Bush 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 Daniel Drive, Lothian, MD 20711 Sherry Ann Bush, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05-09-2007 | Huntingtown, MD Emmanuel Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying such s cardiac or respiratory arr. st, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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Certification:

Medical

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-trai attending physician for use as the buria ed by the a has been signed I je 2 should be det page certificate

requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

r death.

To the Hospital or within 24 hours af To the Funeral D

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filled in by

funeral director, After this after death

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Hospital: 1 Tyes 21X/No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

24a. Was an autopsy performéd? 2

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29d. Date signed (Mpnth, Day, Year) 29c. License number 29b. Signature and title of certifler

30. Name and address of perse ho completed cause of death (Item 23a) (Type, Print) 8

State Registrar

31. Date filed (Month, Day, Year) MAY

32. Registra Signature 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2007 0435 A M Rev. Mario Bugliosi, O.S.F.S. May 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Annecy Hall @ DeSales Center Childs If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 3 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours tX M 2 □ F Months Albano, Italy 87 Director 221-56-0593 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov the Medical Examiner must be notified at Childs MD Cecil 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ USA 21916 1120 Blue Ball Road or itema 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. iled within 72 hours after ☐Yes 2☐No Yes, Give 1X Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ρ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itam 27 la marked other than *na any injury or other traumatic avant. The Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Church/Religion 5+ Priest 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Aurelio Bugliosi Ida Bongianni ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Dougherty 911 N. Rodney St. Wilmington, DE 19806 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Cimitero Comunale di Albano Lazile 1 Burial 2 Cremation 3 Removal from State May 24 2007 4 □Donation 5 🖫 Sther (Specify) entombment Albano, Rome, Italy 22. Name and Address of Facility Corleto Latina Funeral Home Signature of Funeral Service Licensee 2506 Concord Pike Wilmington, DE 233 Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** CVA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of deliver 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pot Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a ate hes been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 2 INO 3 Probably 4 □Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 No 1 Yes 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 hesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No this After this funeral c 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No iours after death.

neral Director: A
filled in by the fo investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gloria Simonson, M.D., 111 W. High St., Suite 302, Elkton, MD 21921 10 32. Resstrar's Signature 31. Date filed (Month, Day, Year) MAY 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Day **Physician** 04:06 PM M John P. Buckalew, Sr. May 09, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 92 Spring Street Allegany Frostburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Min 1 M 2 □ F 216-14-1853 88 Director Maryland October 05, 1918 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 92 Spring Street Funeral 21532-12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWJI 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) supervisor natural gas distributor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Britt B. Buckalew Mary Hansel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 an.
Department of Health
Important: If Item 27:
any Injury or other tra Alta Buckalew wife 92 Spring Street Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park May 12, 2007 Frostburg Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) ENTE MYOCANDIAL INFARCTION **Physician** /Medical ATTH-TROSCLEROTIC CARRIOVASWUM DISI-MSTE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform ospital or Attending Physiclan: Ti hours after death. uneral Director: After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 1 Yes 20 No ٩ 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title D50844 5/1UA

Registrar

nes

State

31. Date filed (Month, Day)

MAY

WHEREA JR.

MD 912 FITON DRIVE COMBETRIAND, MD 21502

who completed cause of death (item 23a) (Type, Print)

\$2. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CLEMENTINE WILLETTS BRAIN 5 2007 10:55 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ALLEGANY FROSTBURG VILLAGE NURSING HOME FROSTBURG If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🖫 F 94 Yrs Director 212-38-6127 3-24-1913 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28e-f show the Medical Examiner must be notified at Y Yes 2 No Directo FROSTBURG MD ALLEGANY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 100 HONEYSUCKLE LANE APT 423 21532 UNITED STATES 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 3X Widowed 4 ☐ Divorced 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4 College (1-4or 5+) Elementary/Secondary (0-12) TRAVEL COORDINATOR WILLETTS TRAVEL, INC. permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Importent: If item 27 Is marked other 1 any injury or other treumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) AGNES SHAW PEARCE THOMAS PEARCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5656 CALYN ROAD, BALTIMORE MD 21228 JOHN WILLETTS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY BOARD OF MD 5-7-2007 BALTIMORE, MD 4 X Donation 5 ☐ Other (Specify) 60 W. MAIN STREET 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 DWCFS MO0547 Enter the disease 23a. Part1. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary disease or condition resulting in death) years /Medical Examiner Sequentially list conditions, if any, leading to immediate the sequence of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 Mo I or Attending Physicien: after death, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Soursing Home 5 Residence 6 Other (Specify) funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospitel within 24 hours To the Funerel 29a. Certifier Descritiying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tot

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State Registrar

3

30. Name and address are son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last, Month 20m Day Year Physician 000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner norsing 3 Rehab hab Center Age (In yrs. last birthday) C10011 orien Birthplace (State or Foreign Country)
 PA 5. Social Security Number **Funeral** Days 1 M 2 XF Months Hours 90 173 - 03 -2141 Apr Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State 1 XYes 2 No Director MD Carroll Taneytown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21787 100 Antrim Blvd. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Church school Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine Kissel Elmer Blair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Heelth a Important: if item 27 is any injury or other trai once. 100 Antrim Blvd., Taneytown, MD 21787 Edward E. Bitner spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRemoval from State Green Hill Cemetery May 9, 2007 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Synature of Funeral Service 50 S. Broad St., Waynesboro, PA 17268 23a. Part. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

filed within 72 hours after death with the Maryland

21215-0036

Baltimore, Maryland

or 28a-f show

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Hygiene.

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the Mudical Examiner must be notified at

other traumatic event,

ysiclen and le burial-transit Completed by Physician/Medical phys the L use as signed by the ed Be 2 After the Certification: Director:

Hospitel or Attending Physician: The law requires that the death certificate be executed

certificete

death.

hours after within 24 hours a

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To the h

P.O. Box 68760

Division of Vital Records,

25. Was case referred to medical examiner?

1 ☐ Yes 2 X No

5 Pending

investigation

6 Could not be

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

3 DOA

24a. Was an autopsy performs

1□ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of De	ath (Ci	төск	only one	8)	
her: 4 Nursing	Home	5 🗆	Reside	nce	6 ☐Other (Specify)
The state of the s		_			and and

28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hospital:

1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)

d address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month. MAY 0 8 2007

32. Registrar's Signature

2 ER/Outpatient

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Lest) 1, 2007 Month **Physician** Bromberg Milton 2:11a May /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Montgomery Manor Care Chevy Chase Chevy Chase If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, year) 10/13/1916 New Jersey 5. Social Security Number 168-12-8444 7. Age (In yrs. last birthday) 90 vrs 6. Sex **Funeral** Days Hours Months 1 M M 2 □ F Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Montgomery MD 1 ☐ Yes 2 No Chevy Chase Funeral Director 10g. Citizen of Whet Country?

10f. Zip Code

1 ☐ Yes 2 TNo

20815

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Furniture Dealer

5 Lemans Place

20b. Place of Disposition (Name of

13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)

Specify

USA

18. Mother's Name (First, Middle, Maiden Sumame)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
5 Lemans Place Pine Brook, New Jersey07058

Date

Rae Harrison

Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Furniture

20c. Location - City or Town, State

Pages 1 end 2 should be filed within 72 hours after death with the Marylend rai', or frems 23a or 28a-f show Exeminer must be notified at Baltimore, Maryland 21215-0020 Department of Health and Mental Hygiane. Important: If Item 27 is marked other than 'amy injury or other traumetic event, the Me once.

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Completed

Be

10e. Street end Number

1 □ Never Married 2 □ Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17. Fether's Name (First, Middle, Lest)

Charles Bromberg

19a. Informant's Name/Relationship (Type, Print)

Arthur D.Bromberg/Son

12

11. Marital Stetus

8100 Connecticut Avenue #1619

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U,S. Armed Forces? 1 12 Yes 2 □ No 194 If Yes, Give 194

Year or Dates

College (1-4or 5+)

1942

1945

Physician /Medical **Examiner**

Hospital or Attending Physician: The law requires that the death certificate be executed nours efter death.

neral Director: After this

filled in by the funerel di within 24 hours e

Division of Vital Records, P.O. Box 68760,

	Removal from State	f Disposition (Name of ry, crematory or other place) Cemple Emanuel Ce	Date 20c. Location - City	
4 Donation 5 Other (Specification 21. Signature of Laeral Service Licer	11	132-Name and Address of Facility L.I.	DI FUNERAL SERV Blvd.Silver Spr	ICE, P.A.
23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Dnset and Death
Immediate Cause (Final disease or condition	Myocardial	Infarction		10wks
resulting in death)	Due to (or es a	consequence of):		
	Atheroscle	cotic Heart Disea	ase	years
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	0	consequence of):		
that initiated events resulting in death) Last	Due to (or as e	consequence of):		
End stage rea	lai disease			
			performed?	4b. Were autopsy findings available prior to completion of cause of death?
25. Was accordaryed to medical		Ge Place of D	performed?	available prior to completion of cause
25. Was case referred to medical examiner?	Hospital:		performed?	available priof to completion of cause of death?
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Dey Year)		performed?	available priof to completion of cause of death?
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Dey Year)	trpatient 3	eath (Check only one) Home 5 Residence 6 Other (3	available priof to completion of cause of death? 1 □ Yes 2 □ No Specify)
25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Dey Year) 28b. Place of Injury - At home, fabuilding, etc. (Specify)	trpatient 3	eath (Check only one) Home 5 Residence 6 Other (Street and Number of City or Town, State)	available prior to completion of cause of death? 1 Yes 2 No Specify) or Rural Route Number,
examiner? 1	28a. Date of Injury 28b. (Month, Dey Year) 28e. Place of Injury - At home, fabuilding, etc. (Specify) yelcien: To the best of my knowledgininer: On the basis of examination ar	trpatient 3 □ DOA Other: 4 ☑ Nursing Time of njury M 28c. Injury at Work? M 1 □ Yes 2 □ No arm, street, factory, office	eath (Check only one) Home 5 Residence 6 Other (Street and Number of City or Town, State)	available prior to completion of cause of death? 1 Yes 2 No Specify) or Rural Route Number, ar as stated, due to the cause(s)
25. Was case referred to medical examiner? 1	28a. Date of Injury 28b. (Month, Dey Year) 28e. Place of Injury - At home, fabuilding, etc. (Specify) ysicien: To the best of my knowledgrainer: On the basis of examination an and manner stated.	Atpatient 3 DOA Other: 4 Nursing 1 Nursing 28c. Injury at Work? M 1 Yes 2 No Arm, street, factory, office 29c. Icense number 29c. License number	eath (Check only one) Home 5 Residence 6 Other (3 28d. Describe how injury occurred 28f. Location (Street and Number of City or Town, State) ce, and due to the cause(s) and manne curred at the time, date and place, and	available priof to completion of cause of death? 1 Yes 2 No Specify) or Rural Route Number, ar as stated, due to the cause(s)
Kama	28a. Date of Injury 28b. (Month, Dey Year) 28e. Place of Injury - At home, fabuilding, etc. (Specify) yelcien: To the best of my knowledgniner: On the basis of examination are and manner stated.	Atpatient 3 DOA Other: 4 Nursing 1 Nursing 28c. Injury at Work? M 1 Yes 2 No Arm, street, factory, office 29c. Icense number 29c. License number	eath (Check only one) Home 5 Residence 6 Other (3 28d. Describe how injury occurred 28f. Location (Street and Number of City or Town, State) ce, and due to the cause(s) and manne curred at the time, date and place, and 29d. Date signed (May 1,	available priof to completion of cause of death? 1 Yes 2 No Specify) or Rural Route Number, er as stated, due to the cause(s) Month, Day, Year) 2007

DHMH 16 Rev 6/95

Registrar

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7	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	de de	c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In vis. last birthda	ay) If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	9. Birthplace (State or Foreign
	Director		233-50-2279 1 [™] 2□F 73 Yrs.	Months Days Hours Min.	Month, Day, Year uly 18,	1933 West Virginia
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location		10d. Inside City Limits
	Maryl f eho	ŗo	Maryland Montgomery Damaso	2118		1 ☐ Yes 2 XNo
	n the	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ath wil		24637 Showbarn Circle	20872		U.S.A.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Medical Examinar must be milliad at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Myes 2 No If Yes, Give Year or Dates: Korean	 Was Decadent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2	Yes or No- in, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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218	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)		11 Service soline Station
N	filed w Hygier other th		12 Bt 17. Father's Name (First, Middle, Last)	usiness Owner 18. Mother's Name (Fi		
and	d be f ental h ked of c eve	To Be	Quill Bonds	Daffie	Clay	
Maryland	2 should be and Mental is marked sumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rural Ro		or Town, State, Zip Code)
	1 and 2 Health a tem 27 is			637 Showbarn Circle,		
Baltimore,	ges 1 t of He if iter		cemetery, o	sposition (Name of Date crematory or other place)		Location - City or Town, State
ti E	t. Pag rtment rtent:		4 Donation 5 Other (Specify)	litan Crematorium 5/1	.1/0/ Ale	xandria, Virginia
Ba	permit. Pages 'Deportment of Himportent: If Ite		Novere a. summe.	.22. Name and Address of Facility Molesworth-Williams F 26401 Ridge Road, Da	mascus,	Maryland 20872
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	6. å 4	spiratory arrest,	Approximate Interval Between Onset and Death
ų,	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	onito		Imonth
ı	Examiner		Sequentially list conditions L. Immunocor	npromise		3months
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ũ		Medi	IF FEMALE:			
Вох	death certific e attending p id for use as	lan/I	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
0		yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)		
<u>a</u>	ires that the signed by th I be detache	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	e undertying cause given in Part I.		use contribute to the cause of death?
Division of Vital Records,	w requires t been signe should be	Completed			24a. Was an	24b. Were autopsy findings available
Bě	has has	duic			autopsy performed/?	prior to completion of cause of death?
ital	ilcien: Th certificate rector, pag	BeC	25. Was case referred to medical	26. Place of Death (C	1□ Yes 2√N heck only one)	0 10163 20140
× <	\$ & B	2	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpa			6 ☐Other (Specify)
Ň	ttending Ph death. stor: After th the funeral	i.c	27. Magner of Teath 1 Natural 5 □ Pending 28a. Tate of Injury (Month, Day Year) 1 Injur		. Describe how inj	ury occurred
isio	or Attending after death. Director: After in by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm,		Location (Street a	and Number or Rural Route Number,
Š	5 th th c	Certi	4 Homicide determined building, etc. (Specify)	, , ,	City or Town, Sta	te)
	4 T S	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dependent on the basis of examination and/of and manner stated.	eath occurred at the time, date and place, and r investigation, in my opinion, death occurred a	due to the cause(at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
)	Dr.		Keith Fronts Medical Poe	tor Res-000	MA	4 4 2007
١	OHAL		30. Name and address of person who completed cause of death (Item 23a) (Ty		a [
	Sta	te.	31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	had I HOSPITAL, GOU	100RTh Wo	He Starct, PAlt-MORE ND
	Regist		MAY 0.7 2007 Japane 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year BUNGETTE PAMELA MA-20 2007 0200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y)
June 29, Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours Year. 1 □ M 212-64-7207 52 1954 | Maryland Usual Residence of Decedent 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2X No Maryland | Montgomery Bovds 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23220 Shilo Church Road 20841 U.S.A. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White ξ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Services Giant Food Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer F. Fletcher, Jr. Eileen Hady Rohrbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Burdette - Husband 23220 Shilo Church Road, Boyds, Maryland 20841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematorium 4/5/07 Alexandria, Virginia 4 □ Donation 5 Other (Specify) 21. Signature of Fureral Services icensee 22. Name and Address of Facility Molesworth—Williams P.A., Funeral Home overt o 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER WELVEL BLIC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No 9∐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

P.O. Box 68760. Division or Vital Records,

or Attending Physician; The law requires that the death certificate be executed g physician and as the burial-tr as attending properties of the second se use signed by the a s certificate has be irector, page 2 s ours after death.

eral Director: After this certification in by the funeral director, To the Hospitai e Funeral within 2 To the

Physician

/Medical

Examiner

Directo

Funeral

Completed

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Examine

Physician/Medical

Completed by

Be

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Medical Certification:

3 ☐ Suicide

29a. Certifier (Check only one)

4 THomicide

29b. Signature and title of

31. Date filed (Month, Day, Year)

MAY 0

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

JOSEPH KAPLAN,

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OLNEY

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of perso who completed cause of death (Item 23a) (Type, Print)

2007

Philip Drive

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician HERBERT CARROLL 2007 2252 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

DC 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Days Year) Hours 1 XM 2 □ F 579-07-6669 89 19, 1917 Director Aug. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits r 28a-f show notified at 1 □ Yes 2X No Director MD Prince Georges Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be to 7513 Blanford Dr. 20744 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Park Policeman Dept.of Interior 3 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wesley Carroll ပ Anna DeTharta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7513 Blanford Dr. 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum once. Sandra E. Carroll Williams/Dtr Ft. Washington, MD. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National 5-8-2007 Triangle, Va. 21. Signature of Functial Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Ma 00 Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner requires that the death certificate be executed the burial-trai Due to (or as a consequence of): attending physician for use as the hirial Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifie 14 Certifying Physigian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifie n who campleted cause of death (Item 23a) (Type, Print) 30. Name and address of pe ver SPRINS 6 32. Registrar's Signat Year) 31. Date filed (Month. State 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29, 2007 Month **Physician** Bernard Luther Copsey April 3:12 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 38070 Hunter Ct. Charlotte Hall St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1930 Maryland If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) May 20, 1 **Funeral** Days Hours 1 → M 2 □ F 214-28-9716 76 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show ant; if Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvland St. Mary's Charlotte Hall 1 □Yes Z☐No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38070 Hunter Ct. Funeral I 20622 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No 148 ☐ 55 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Department of Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Luther Copsey Gertrude Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Mills/daughter 38070 Hunter Ct., Charlotte Hall, MD 20622 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once, injury or Charles Mem. Gardens May 2, 2007 Leonardtown, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service License Dep 9 30195 Three Notch Rd., Charlotte Hall. MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of) **Examiner** Coronary Artery Disease Sequentially list conditions, if any, reading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for sele consequence of To the Hospital or Attending Physician: The law requires that the death curtificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and Hypertension burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Osteopenia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 X No 24a. Was an Compression Fractures autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signatur D55027 5-2-2007 who completed cause of death (Item 23a) (Type, Print) 30 Name and address Panwala, Day, Year) Market Dr., 2nd Floor, Charlotte Hall, MD 20622 Manoj
31. Date filed (Month, Coords Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Paul Howard Curtis May 2007 5:20 P^{M} 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 512 Wesley Court, #543 Solomons If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Social Security Number Year Months 1 M 2 ☐ F Feb. 1925 Washington, DC 82 578-20-9344 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Calvert Solomons 5 4 1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20688 United States 512 Wesley Court, 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institute of Elementary/Secondary (0-12) College (1-4or 5+) Psychiatric Social Worker Mental Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Virginia Mahoney Archie Briggs Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 512 Wesley Court, #543, Solomons, Maryland 20688 Rose Rebecca Curtis (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burlal 2 🗷 Cremation 3 ☐ Removal from State Metropolitan Crematory 5/03/07 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung cancer years disease or condition resulting in death) Due to (or a consequence of): Myelodysplastic Syndrome ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ears cancel KIN resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.25-No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√ No 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? (Month, Day Year)

Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, signed by the s page certificate After t death Director: hours after

Physician

/Medical

Examiner

Funeral

Director

be filed within 72 hours after death with the Maryland ntal Hygiene.

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Physician

/Medical

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f shov

traumatic event, the Medical

Director

Funeral

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Examine Physician/Medical þ Completed Be Certification: To 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Example 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

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State

Registrar

within 24 hours a To the Funeral C filled

Hospital

D0059061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Koaa PATEL

31. Date filed (Month, Day, Year)

29b. Signature and title of pertities

3 2007 MAY

32. Registrar's Signature

29c, License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05 **Physician** 2007 LORETTA MAE CHRISTMAN 2210 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year. 1 □ M 2 ▼F Days Hours 75 215-26-9506 March 13,1932 Director Usual Residence of Decedent 10c. City. Town or Location a or 28a-f show be notified at 10d Inside City Limits 1 XYes 2 □ No Director Cumberland MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe items 23a Iner must b 21502 USA 1510 B Oldtowne Manor Apts. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinar must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 M Married White 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing aid Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Evelyn (Paxton) William Guy Hill P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12814 Lewis Heights Dr SW, LaVale, MD 21502 19a. Informant's Name/Relationship (Type. Print) Loretta Kerns / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park: 5/15/07 Cumberland, MD 4 Donation 5 Dother (Specify) 21. Signatur of uneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 ale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of sach line. Approximate Interval Between Onset and Death Immediate Cause (Final CENEBIO VASULUAR Physician disease or condition resulting in death) DAYS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnantin the past 12 mooths? 3 Ectopic pregnancy 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 210 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rector, page 2 2 0 No uneral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Dinpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) 1 Watural 1 □ Yes 2 □ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 05/13/2007

Registrar
DHMH 17 Rev 1/2001

State

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700

30. Name and address of person

31. Date filed (Month, Day, Year)

)0

MD

912 STON PIZIVE CUMBERLAND, MD 21502

ho completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

OVERLAJE.

07-03244		Please Type or Print in Black Indelible Ink. Ensure All Copi		gible.	
Donnie J. Coopei		State of Maryland / Department of Health and Mental F	łygiene	200	7 16225
Disconicio	_	Registrar Certificate of Death	2. Date of Deat	g. No.	3. Time of Death
Physicia Medical Examin			Month April 28, 2	Day Year	1 1215 hrs
		Donnie J. Cooper, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Deat	<u></u>
li .		University Hospital Baltimore			
Funeral	╗	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I f Under 24Hr		th(MM/DD/YYYY) 9. Bi Forei	thplace (State or
Director	١	213-96-6617 1XM 2 F 27 Yrs. Months Days Hours Mil	02-22-	1980	Maryland
	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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ne Maryland or 28a-f show fied at once.	흱	Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	
or 28	Director				,.
r death with the Maryland or items 23a or 28a-f sho must be notified at once		1039 Camelia Circle 21613 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		SA 14. Race - Amer	ican Indian, Black,
leath v	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		White, etc.	
after c	by F	3 Wildowed 4 Divorced If Yes Give Year 1 Ves 2 No. specific		· Specify: B1a	ack
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36 in 72 han "; lical F	흺	Elementary/Secondary (0-12) College (1-4 or 5+)	,		
215-0036 be filed within 7 hal Hygiene. ked other than ent, the Medica	Completed	12 Welder 17. Father's Name (First, Middle, Last) Welder 18. Mother's Nam	ne (First, Middle, N	Will Bro	owns
215.	Be		, , ,	Mouring	
213 ould b d Men s marl		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			e, Zip Code)
MD d 2 shc and the and and 27 is aumati		Shirlene Mouring / Mother 1039 Camelia Circle 20a. Method of Disposition (Name of cemetery,	. Cambri	dge Marylaı	nd 21613
re, slam of Hea of Hea		crematory or other place)	Date	20c. Location - City o	Town, State
Page Page nent o		4 Donation 5 Other Specify: Church Cemetery 05-	05-2007	East NewMa	arket.Md.
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	- [21. Name and A dress of Facility Rennie Smith Fund	eral Hom	e	
		524 Race Street, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Cambrid	ge Maryland	1 21613 Approximate Interval
Physician /Medical		fallure. List only one cause on each line.	or respiratory arm	est, shock, or near	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Stab Wound of Chest Due to (or as a consequence of):			Dedui
7		Sequentially list conditions.			2
	힐	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
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executed an and al - trans	calE				<u> </u>
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68760, certificate be nding physici se as the buri.	cian/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregram	ancy	23d. Date of deliver	Ty Day Year
x 68 h certi tendin	icia	past 12 months? 1	iarioy	I Working	Day Tour
Box te death c the atten	Physi	Yes 2 No 9 Unknown 9 Unknown			
n of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	by P		23e. Did to	obacco use contribute to s 2 ✓ No 3 Pro	the cause of death?
S, F quires en sign			24a. Was		utopsy findings available
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of Vital Records, ig Physician: The law requir the this certificate has been s neral director, page 2 should	Be			Decidence C Other	
of V Phys ter this	ျ	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work?		Residence 6 Other	er:
on of Anding Phuth	ion	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Apr 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 29a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	Subject stat		
Division al or Attendiu rs after death al Director: A led in by the fu	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Divisior spital or Attend hours after death hours after death uneral Director:	erti		or Town, S 600 block Pin	^{state)} e Street, Cambridge	MD
Hosp 24 hc Fund etely f	S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date		
	≥			29d. Date signed (Mo	ontn, Day,Year)
2	Į	O.C.M.E.		April 29, 2007	
		30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, I	MD 21201		
Str	ate				
Regist	rar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 0515 April MILLY F. COBURN 6 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner der 1 Year | If Under 24 Hrs. hs Days | Hours | Min. Talbot Memori 8. Date of Birth (Month, Day, Year, Under 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 K F MAR 10, 1941 MARYLAND 66 215-38-1598 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director MD TALBOT **EASTON** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8570 SWAN HAVEN ROAD 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: þ 3 ☐ Widowed 4 T Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COOK 10 RESTAURANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TINA HERMANN/DAUGHTER 1455 WILLEYTON ROAD, GATES, NC 27937 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 4/27/07 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 Joseph M. C.F.SR Ustasushi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year Chrone **Physician** 66 Spectre /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and as the burial-tran-Due to (or as a consequence of) attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Nes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural

Division or Vital Records, P.O. Box 68760, in 24 hours after death.

the Funeral Director: Appletely filled in by the fi

5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

APR 30

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monte us 31. Date filed (Month, Day, Year) egistrar's Signature

State Registrar

Medical

29a. Certifier

within 2

			For State Registrar	State	of Mar			ment of H ficate of L		and Me		giene Reg. No	211111	16227
			1. Decedent's Name (First, Middle	e, Last)			_				2. Date of De	ath Da	y Year	3. Time of Death
	Physicia /Medic		MARJORIE MAY CU	JLPEPPER							APRIL	30,	2007	07:32A M
	Examin		4a. Facility Name (If not institution				41	b. City, Town, or				40	. County of Dea	
			SHADY GROVE ADV	ENTIST 6. Sex		CAL In yrs. last birth	hday) l	ROCE f Under 1 Year	(VILL)		8. Date of Bir	th.	9 Bir	MONTGOMERY thplace (State or Foreign
E	Funeral Director		5. Social Security Number $541-20-4352$	1 M 2 X		0.0		lonths Days	Hours	Min	(Month, Da 03/23/	av. Year) [C	OR
	and w	-	Usual Residence of Decedent 10a, State 10b. County		1	I0c. City, Town	or Locati	ion						10d. Inside City Limits
	Maryli f sho ied at	ō	MD MONT	GOMERY		DΔM	ASCU	2						1 ☐ Yes 2 X No
	the 28a-	Director	10e. Street and Number	GOILLE		DIMI		10f. Zip Code			T	10g. Ci	tizen of What C	ountry?
	h with	a D	26401 PURDUM RO	AD					20	872				U.S.A.
336	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 25 Marr 3 ☐ Widowed 4 ☐ Divorced	ried Armed	Decedent Ev d Forces? es 2 X No , Give or Dates:			s Decedent of Hes, specify Cuba	ispanic Ori an, Mexicar Specify:	gin? (Spe n, Puerto P	cify Yes or No Rican, etc.))-	14. Race - Am Black, Whi Specify:	
ğ	'2 hot natura ical E	ted	15. Deceden	t's Education	ed)	16a. 1	Deceden	t's Usual Occup d of work done	ation	t of workin	20	16b. k	Kind of Business	/Industry
215	thin 7	Completed	Elementary/Secondary (0-12)	Colleg	ge (1-4or 5+)		life. DO	NOT use retired	1)		.9			
2	filed wi Hygien ther th	ပ္ပ			2	1]	HOMEMAKI		or'o Namo	(First, Middle	Maida	OWN HON	1E
E E	be fill ad oth even	Be	17. Father's Name (First, Middle, HARVEY McPHERSO	•							ERSON	, ivialue	i Surname)	
3	should be ind Mental imarked o umatic eve	ဥ	19a, Informant's Name/Relations			19h	Mailing A	Address (Street				ner. City	or Town, State,	Zip Code)
, Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		HARRIS CULPEPPE		ND	26	401	PURDUM I		DAMA	SCUS,	MD	20872	
altimore,	6 O		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5	Specify)	rom State		y, cremat AL C	ory or other place REMATOR	IUM	05/11	ate ./2007	FA]		RCH, VIRGINIA
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service				10	91 ROCK	VILLE	PIKE	ROCK	CVIL	ON, INC	(LAND 20852
	Physician /Medical		23a. Part Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. ST	REP	he death. Do n		the mode of dyir	ng, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death 2 WEEKS
	Examiner				EUMON:)i).							2 WEEKS
52		ē	Sequentially list conditions, if any, leading to immediate	D		consequence o	of):							2 WILKS
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	s SE	PSIS									2 WEEKS
ó	exec an an rial-tr	Exa	resulting in death) Last	Due	e to (or as a	consequence o	of):							0 115570
8760,	ficate be executed physician and is the burial-transit	dical		d. AC	UTE RI	ENAL FA	ILUR	E						2 WEEKS
Vital Records, P.O. Box 6	eath certi attending for use a	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 □ L 4 □ P				ctopic pregnanc other <i>(specify)</i>	у				23d. Date of d Month	elivery Day Year
JS, P	w requires that the de been signed by the should be detached	by Pł	Part II. Other significant conditions HYPONITREMIA	ons contributing	to death but	not resulting in	the unde	erlying cause giv	ren in Part	l.				to the cause of death? Probably 4 Xunknown
Ö	requ	etec									24a. Wa			autopsy findings available
Be	The law ate has page 2 s	ldmo									auto	opsy formed?	prior to death?	completion of cause of
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medica examiner?							e of Death	(Check only	one)		
7	g :s :g	To I	1 ☐ Yes 2X No			t 2 ☐ ER/Out	<u>'</u>		4 LI N				6 ☐Other (Sp	ecify)
n o	Attending Physician: or death. rector: After this certification by the funeral director, I		27. Manner of Death 1X Natural 5 □ Pendi	ng (Date of Injury Month, Day		Time of njury	28c. Injui Woi		-	28d. Describe	how inj	ury occurred	
Sio	tend leath. tor: /	cati	2 Accident invest 3 Suicide 6 Could	not be	lose of injur	At home for	rm etroo		Yes 2		28f Location	(Street	and Number or I	Rural Route Number,
Division or	ital or Attenors after deathers after deather all Director: led in by the	Certification:	4 ☐ Homicide determ	nined 200. F	ouilding, etc.	(Specify)	iiii, stree	t, factory, office			City or To	own, Sta	te)	ina rione ranioe,
	Hosp 4 hou Fune Fely fil	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medica		o the best of the basis of manner stat	examination an	e, death o d/or inve	stigation, in my	me, date a opinion, de	nd place, ath occurr	and due to the red at the time	e cause(e, date a	s) and manner nd place, and d	as stated. ue to the cause(s)
	To the within 2 To the complex	M	29b. Signature and title of certific	er /	7			29c. Licens	se number			29d. D	ate signed (Mo	nth, Day, Year)
	5		frist 1	Int (4	M.	D.	D00	06444	4			APRIL 3	30, 2007
*	·		30. Name and address of person					nt) R DRIVE	, ROC	KVILI	LE, MAF	RYLA	ND 208	50
	Sta Regist		31. Date filed (Month, Day, Year	4 2007	32. Sistra	r's Signature	do	WE .						
	7 40 60 7 7				A		7							

			For State Registrar	State of Maryla		rtificate of			giene leg. No. 2007	16228
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		Russell	Craig Coff:	in			May	3, 2007	2:40 A.M
	Examin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dea	th	4c. County of Death	1
e.			805 Woodland Avenu			Thurmo			Frederic	
	Funeral		5. Social Security Number 6. Sex	M 2DE	i. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	(Month, Day	9. Birth	pplace (State or Foreign untry)
3.0	Director		230-54-4578 Usual Residence of Decedent	62	110.			March 2	4,1945 Wash	ington, DC
	land ow t		10a. State 10b. County	10c. C	ity, Town or Lo	cation	·			10d. Inside City Limits
	Mary -f sh fied a	후	Maryland Frederick	. 1	Churmon	t				1X Yes 2 □ No
	r 28a	Directo	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What Co	untry?
	th with stands		805 Woodland Avenu	e		217			United St	
	ems er m.	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
9	or it	짓	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give	1	1 ☐ Yes 2 ☒ No	Specify:		Specify:	1
21215-0036	hours rural"	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	16a Dece	dent's Usual Occur	nation		16b. Kind of Business/I	hite
5	n 72 i "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	I (Give	kind of work done	during most of we	orking		,
12	withi iene. than	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Mecha	nical De	signer		Federal Go	vernment
0	lid be filed within 72 hours after death with the Maryland lental Hygjene. ked other than "natural", or items 23a or 28a-f show ite event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	ıme (First, Middle,	Maiden Surname)	
lan	uld be Aenta rked tic ev	To B	Barrett	Coffin				Julia	Clark	
Maryland	shoi and N s ma		19a. Informant's Name/Relationship (Typ	oe. Print)		,			er, City or Town, State, Z	
Σ	and 2 ealth n 27 I		Lisa A. Jones/Daug	hter					Maryland 2	
altimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ R	emoval from State		sition (Name of matory or other pla	1	Date	20c. Location - City or	,
Ē	. Pag tment tant: jury o		4 □ Donation 5 □ Other (Specify)			tan Crema			Alexandria	, Virginia
Bail	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	21 Signature of Funeral Service License					eVol Fune		m 20077
	TD = 60 01		23a Parti Enter the disease or compli	cations that caused the de-	ath Do not ent	East De	er Park	Dr., Galt	hersburg, l	Approximate
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final			113	LTIFO	DMI	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	45/20MJ	4 190	(1,50	7 (6		11 MUNTS
	Examiner			Dao to (01 as a solitor	squarios oi,					
	3 7 3	횰	Sequentially list conditions, if any, leading to immediate	Due to (or as a our se	equanca of):					
	cuted nd ransit	Examiner	days, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó,	e exe ian ar urial-t	Ë	resulting in death) Last	Due to (or as a conse	equence of):					
68760,	ficate be executed physician and is the burial-transit	edical		1						
9 ×	ertific ding p		IF FEMALE:	3c. If yes, outcome pf preg	mancy				23d. Date of del	h.or.
Вох	eath cattence	ian	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnanc	у		Month	Day Year
P.O.	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	, dodin	_ (opcony) _				
σ.	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	4	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
rds	quires n sign	d by				· · · · · ·		1 🗆 1	/es 2∭No 3⊟Pr	obably 4 Unknown
000	aw requir s been si s should	Completed						24a. Was	an 24b. Were au	Itopsy findings available completion of cause of
R	The la	E O				_		perfo	rmed? death? 2 No 1 ☐ Yes	_
ta	lan: rtifica	BeC	25. Was case referred to medical				26. Place of D	eath (Check only o		
<u>_</u>	ding Physician: The lavh. h. After this certificate has funeral director, page 2	TO E	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	IL SUDOA	her: 4 \(\sum \) Nursing	Home 5 Resid	dence 6 ☐Other (Spe	cify)
0	ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo		28d. Describe I	now injury occurred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	On Bloom of injury At	hama farm at]Yes 2 □ No	20f Location /	Street and Number or Ri	iral Rauta Number
Division or Vital Records,	or At ifter d Direct in by	Certification:	4 Homicide determined	28e. Place of injury - At building, etc. (Spe	cify)	reet, lactory, office		City or Tov		arai noute Number,
	pital ours a leral filled		29a. Certifier 1 Certifying Physics	sician: To the best of my k	nowledge, dea	th occurred at the t	time, date and pla	ce, and due to the	cause(s) and manner as	s stated.
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical		ner: On the basis of exami and manner stated.						
	within Fo th	Me	29b. Signature and title of certifier)			se number		29d. Date signed (Mont	
	15		Ahanto Ta	UMMON	M) 43	23683		5/3/07	
			30. Name and address of pers in who co	ompleted cause of death (It	em 23a) (Type	Print)	(1	550 WILLIAM	u Sr. MO 21231
			STUART A CARSSMO		situs le	OVKINS (ANCER	eruer	BAZTIMORE	MO 2/23
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	mature	7 Al				

State Registrar

MAY 0 4 2007

			For Stata Registrar		State of M	laryland / Dep <i>Ce</i>	artment of H rtificate of I			giene () () 7	16229
	Physici	an	1. Decedent's Name						2. Date of Dea Month	Day Year	3. Time of Death
3	/Media	al	Hele 4a. Facility Name (If n	en Loret			41. Cit. T-	1000		, 2007	3:15P. [™]
	Examin	er	1.11	ot institution, give s ollow Rd)		r Location of Death iddletor		4c. County of Dea	m erick
	Funeral		5. Social Security Nur	mber 6. Sex	7. A	ge (In yrs. last birthday	-	If Under 24 Hrs. Hours Min.			thplace (State or Foreign ountry)
	* Director		228-50-5		M ZZZF	59 Yrs.			reb. I	5, 1930	V A
	yland			10b. County		10c. City, Town or L		<u> </u>			10d. Inside City Limits
	Ba-f et	Director	MD	Freder	ick		Middleto	own			1 ☐ Yes 2 🛣 No
	with the a or 21	Dire	10e. Street and Numb	Hollow	Рd		10f. Zip Code	21769		10g. Citizen of What Co US	
	death	eral	11. Marital Status		2. Was Deceden	Ever in U.S. 13.	Was Decedent of H		pecify Yes or No-		erican Indian,
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or iteme 23a or 28a-f ehow a Mudical Examinar must be notified at	by Funeral	1 ☐ Never Married 3 ☑ Widowed 4		Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	X Io	1 ☐ Yes 2 XNo		o Rican, etc.)	Specify:Wh	
5-0	72 ho 'natur	Completed	1 (Specify	5. Decedent's Educ only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Business	/Industry
121	within ene. than	dmo	Elementary/Second	fary (0-12)	College (1-4or	5+)		1)		military	club
	filed with I Hygiene other tha	Be Co	17. Father's Name (F	irst, Middle, Last)		111	anager	18. Mother's Nam		Maiden Sumame)	CIUD
ylar	should be filed within and Mental Hygiene. is marked other than eumatic event, to he	To B	George	e H. Ros	е			Olzie	Deel		
, Maryland	s 1 and 2 should be filed within 72 he I Health and Mental Hygiene. Item 27 is marked other than "natur other treumatic event, Ite Medical		James G	ne/Relationship (Type • Cody		96 (Conestog	a Ct.,	Hedges	r, City or Town, State, Ville, W	
Baltimore,	ges 1 a t of He If Item or oth		20a. Method of Dispo	sition Cremation 3 R	emoval from State		osition (Name of			20c. Location - City or	
Itim	rtmen rtmen rtant: njury		4 □ Donation 5	Other (Specify)							tsville, M
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tre 2069.		1 must	X/1	W/\$8	I	P. O. Bo	x 18, M	<u>liddlet</u>	neral Homown, MD	21769
ı					e cause on each	d the death. Do not en					Approximate Interval Between Onset and Death
3	Physician /Medical		tmmediate Cause (Fi disease or condition resulting in death)	nai a	Due to /or o	s a consequence of):	42014	L 1scl	1emia		hours
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_	and and II-trans	Examiner	that initiated events resulting in death) La	st c	Due to (or as	s a consequence of):					
68760,	ificate be executed g physician and es the burial-transit	edical E									
	Έ σιώ		IF FEMALE:								
Box	eath cert	Physician/M	23b. Was decedent p	regnant		2 Fetal death 3	Ectopic pregnancy	'		23d. Date of de Month	livery Day Year
P.O.	the de	yslc	1 ☐ Yes 2 ☐ I 9 ☐ Unknown	No	9☐ Unknown	at time of death 5[Other (specify)				
	res that the de signed by the a l be detached t	by PI			,	but not resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contribute I	the cause of death?
ord	w require been sis	ted	can	cer co	chexia				1 U Y	es 2 No 3 P	robably 4 Hinknown
of Vital Records,	a 2 C	Completed							24a. Was a autop perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
/ital	ding Physicien: The I h. After this certificate ha funeral director, page	BeC	25. Was case referred	<u> </u>					th (Check only or	1	
of \	Physicien: r this certifica ral director, i	မ	1 ☐ Yes 2 € No.	o H	ospitat: 1 ☐ tnpati			4 🗆 (4u(3))) g (1		ence 6 Other (Spe	ocity)
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical Co	(Check only 2	☐ Certifying Phys	ar: On the basis	t of my knowledge, deal of examination and/or in	th occurred at the time	ne, date and place pinion, death occu	, and due to the o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRIL 30 2007 12:00Am VICTORIA ANNE DUNCAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** P.G. LANDOVER 1827 BELLE HAVEN DR. #202 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min.A | PRATT, Day 6 ear 946 7. Age (In yrs. last birthday) 61 yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)

ITA **Funeral** 1 ☐ M 2 🗙 F 271 48 4550 Yrs. Director Usual Residence of Decedent parmit. Pagas 1 and 2 should be tilad within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Tre Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location LANDOVER 1 Yes 2 No MD. P.G. Director 10f. Zip Code 20785 10g. Citizen of What Country? 10e. Street and Number USA 1827 BELLE HAVEN DR. #202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CUSTOMER SERVICE ADM. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TAYLOR F. HOWARD II HAZEL JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 0.27, 8.5e) 1827 BELLE HAVEN DR. #202 LANDOVER, MD. MACK H. DUNCAN/HUSBAND 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHELTENHAM VET CEM 5/7/07 CHELTENHAM, MD. ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WATSON F. II. 21. Signature of Funeral Service Licensee 3435 14th ST., N.W. WASH. DC. 20010 Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner /ea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Examiner The law requires that the death certificate be executed attending physician and for usa as tha burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 YNo 4☐ Pregnant at time of death 5 Other (specify) signed by tha a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? 2□ No 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Attar thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30 Jame and address of person who completed cause of death (Item 23a) (Type, Print) milla, Ilalle 4000 IWIKOL, udes 31. Date filed (Month, Day, Year)
MAY 0 4 2007 32. Registrar's Signature State Registrar

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			For State Registrar		State	of Marylar		artmen rtificat			and M		giene	7	162	231
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	/Medic Examin		4a. Facility Name (If no	t institution, giv	e street and n			4b. City,	Town, or	Location o	of Death	- 200-7	4c. County	of Death		
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-: Se	Funeral		5. Social Security Num	ber 6.5	Sex	7. Age (In yrs.		If Under	1 Year	If Under		8. Date of Bir (Month, Da			lace (State	or Forei g n
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Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ott	4	21. Signature of Fune	rai Service Lice	nsee /	_	2					Home, F	A. Ow	ings,	MD	20736
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				11. \$ 9	MA	X)) 4:	5351	1		5/3/9	1.7		
	4		30. Name and addres	s of person who Schi Fr	cal C	use of death (Ite	m 23a) (Type } 6 20	Print) G	(en	belt	Rd,	Suile	U-15 (olle	se P	K
A Acet	Sta Registr		31. Date filed (Month,	Day, Year)	7 2007	Registrat's Sign	nature	Spe	de		,		1110	2	14	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** May 1, 2007 4:35 A. Dorinda Joyce Dement /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 55 Wilson Court Calvert Prince Frederick 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Funeral Days Hours 1 □ M 2 X F Director 579-70-2126 58 Washington, July 4, 1948 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo MD Calvert Prince Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 20678 U.S.A. 5375 Buena Vista Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ white 3 Widowed 4 Divorced natural Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) retail grocer clerk 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked ot Kettner Margaret John Edward Reeves ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 ls 5375 Buena Vista Rd., Prince Frederick, MD 20678 permit. Pages 1 and Department of Healt Important: If item 27 any injury or other to Thomas E. Dement, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) So. Memorial Gardens 05-04-2007 | Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Licen 8325 Mt. Harmony Lane, Owings, MD 20736 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) aucer Metastatic Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and on the Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ labetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 2 Ho 1☐ Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA sister's Other: 2 NO Certification: To 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ ther (Specify) home 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 1 - Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who

31. Date filed (Month, Day, Year)

Rafik A. Nasr, MD

225 Town Square Drive, Lusby, Maryland 20657

completed cause of death (Item 23a) (Type, Print)

(barte)

32. Registrar's Signature

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		For State Registrar	State of	Maryland		rtment of H tificate of L		ınd M		iene eg. No.?	007	16	233
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	or	10a. State 10b. County MD Allege	anu		Town or Loc							10d. Inside 0	City Limits s 2 □ No
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nd 2 alth a 27 is rrtrat		John C. Dav	eul Son		1001	1 Botto	m St		Ellersi	210	MD 21	529	
ss 1 a of Hea item		20a. Method of Disposition		20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other place	e)		Date	20c. Loca	ation - City or	Town, State	
Page nent o		1 MBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		iate	rter	Cemete	ru	5-1	14-2007	Hu	ndman	. PA	
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The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal nt at time of de	death 3□	Ectopic pregnancy Other <i>(specify)</i>	,			23	d. Date of del Month	livery Day	Year
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7.7		30. Name and address of person w	ho completed cause			SeTow D			, ,				
nhs		Eugele NAI	11,N MI	-	9 B	Selow Di	R Cu	mbe	MANd 1	Md.	215	02	
Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Re	giśtrar's Signat	y As	and the a							

Registrar DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 07

2007

32. Registrar's Signature

8 Old Washington Rd Waldock Maryand

			State of Maryland / D	epartment of Health and M Certificate of Death		
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Willard Daniel Norwood Elliott 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 3 200	year 3. Time of Death 7. The County of Death 7. The Death 7. The Death 7. The Death 7. The Death 7. The Death 7. T
	Funeral Director	161	3805 Lloyd Bowen Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	St. Leonard	8. Date of Birth (Month, Day, Yea	Calvert 9. Birthplace (State or Foreign Country)
el.	0	tor	Usual Residence of Decedent 10a. State		Feb 2 193	10d. Inside City Limits
	h with the 23a or 28a	Funeral Director	10e. Street and Number 3805 Lloyd Bowen Road	10f. Zip Code 20685		Citizen of What Country?
036	72 hours after death with the Maryland naturel: or iteme 23a or 28a-f show often Exeminar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	within ene. than	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) Cher	ing	Kind of Business/Industry
Maryland	2 should be filed and Mental Hygid 18 marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Willard Norwood Elliott	18. Mother's Name	e (First, Middle, Maide Vinette Mis	en Sumame)
	1 and Health em 27 ther t		Shirley Elliott- wife 380	Mailing Address (Street and Number or Rura 5 Lloyd Bowen Rd. St Disposition (Name of	. Leonard	
Baltimore,	permit. Pages Department of Importent: If its any njury or o once.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Pau 21. Signature of Funeral Service Licensee	l's Episcopal Church 22. Name and Address of Facility Raus)7 Frinsch Funera	nce Frederick MD 1 Home PA
68760,	Physician and American and Physician and Physician and International Physician and Phy	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d	4405 Broomes Is. Rd. of enter the mode of dying, such as cardiac of the control	Port Repr	ublic MD 20676 Approximate Interval Between
.O. Box	that the death certificat led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Records, P	The law requires that ite has been signed b age 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in Severe Melval Regurgi La	he underlying cause given in Part I.	1 Tes	use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Rec		Be Completed	SIP Melval Value 5 25. Was case referred to medical	20 Core mot	24a. Was an autopsy performed? 1 Yes 2 D	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ō	ding Phys	၉	examiner? 1	ne of 28c. Injury at	me 5 Pesidence 28d. Describe how inj	
Division	ital or Attendurs after deathral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)		City or Town, Sta	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	death occurred at the time, date and place, or investigation, in my opinion, death occurred by the control of t	ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s) ate signed (Month, Day, Year)
)	T with		PAT Munding Phy	zici D 19427		5/4/2007
d	0+1 Sta	te	31. Date filed (Month, Day, Year) 32. Registra Signature	ype, Print) HOSPITAL RD. PRI	MAR	YLAND 20678
36	Registr		MAY 4 2007	of Sperties		

07-03477 William F Evans

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 16236

			- For State Certific	ate of Death	Reg. No.
	hysicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 1228 brs
al	Exami		William Fred Evans		May 6, 2007
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
			Anne Arundel Medical Center		
	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	Foreign
ווע	rector	L	255-42-9357 1XM 2 F 80	Yrs.	09/15/1926 Country) Georgia
	ž		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	w any		Maryland Anne Arundel	Edgewater	1 Yes 2 X No
yland	28a-f show I at once.	후	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Mar	r 28a	Director	321 Colony Point Place	21037	USA
ith th	23a c		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	
ath w	items st be	Funeral	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	
ter de	, or		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1945-46	1 Yes 2 X No specify:	Specify: White
urs af	tural	흥	or Dates.	Decedent's Usual Occupation (Give kind of	
72 ho	n "na al Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	
5-0036 led within 7	Hygiene. other than "nat the Medical Exa	ompleted		elf Employed	Auto Body
5-0 led v	Hygi othe the	ပ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)
121 d be fil	fental narked event,	B	Joseph B. Evans 19a. Informant's Name/Relationship (Type, Print)		Westbrook Rural Route Number, City or Town, State, Zip Code)
D 21 should	and M	٩	Kathleen Evans/ Wife		ace, Edgewater, MD 21037
, MD	lealth and N tem 27 is n traumatic	ŀ	20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, MD 21215-0036 Dermit, Pages I and 2 should be filed within 72 hours after death with the Maryland	nt of H t: If is	İ	1 A Burial 2 Cremation 3 Removal from State	atory or other place)	11 /2007
tim Pag	tmen rtant y or o	-	4 Donation 5 Other Specify: Lakemo	nt Memorial Gardens 05/	11/2007 Davidsonville, Maryland eorge P. Kalas Funeral Home
Bal	Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Licensee		Land Rd. Edgewater, MD 21037
"hv	/sician		23a. Part I. Enter the disease, or complications that caused the death. Do I		or respiratory arrest, shock, or heart Approximate Interval
	edical	8 6	failure. List only one cause of each line.	clerotic cardiovascular d	Detween Onset and
Exa	aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	elefotie endlovascular u	
			Sequentially list conditions, b.		
		Je.	If any, leading to immediate Due to (or as a nonsequence of): cause. Enter Underlying Cause		
· See		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
Mr. F	nd ransit		d		
760,	physician and the burial - transit	Medical	X UNPENDED #25a,27, perME, g868	3. 6/11/07 TT	
760,	physic he bur	Bec	IF FEMALE: 23c. If yes, outcome of pregnance	у	23d. Date of delivery
	attending or use as t	sician/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	nancy Month Day Year
Box 687	atter for us	/sic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)	
О.	ned by the detached f	Phy	Part II. Other significant conditions contributing to death but not result	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Records, P.O. Box 68'	signed be deta	i by			1 Yes 2 No 3 Probably 4 Unknown
ds,	s been s	Completed by			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
00	has le 2 sh	ldm			performed? 1 V Yes 2 No 1 V Yes 2 No
			25. Was case referred to medical	26.Place of Death (Check	
ital	his certificate director, page	Be	examiner? Hospital:	Othor	ing Home 5 Residence 6 Other:
of Vital Records,		<u>유</u>	27. Manner of Death 28a. Date of Injury 28b	. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
	e : 12	l i	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	
Division	ar de	ical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
, Di	pual or At ours after d eral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State)
Div			29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	eath occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.
-	outhin 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o	r investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
	- ≥ = 8	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			Mlana Branell MID	O.C.M.E.	May 7, 2007
			30. Name and address of person who completed cause of death (Item 23a		
	\$		Mélissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD	D 21201
		tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	Smell	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

		•	For State Registrar	State of Ma		ertificate of De			g. No.	1 10201	
	Physicia	an.	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	al .	Milton Edgar ENSM 4a. Fecility Name (If not institution, giv.			4b. City, Town, or Lo	ocation of Death	May 9,	2007 4c. County of Dea	6:50 a. M	
	Examin	er	421 West Church			Hager			Washir		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthda) If Under 1 Year If		8. Date of Birth (Month, Day,	9 Bir	thplace (State or Foreign ountry)	
	Director		212-14-6044	X M 2 □ F	85 Yrs.	Wildfill S Day's	Nan.	April 9	,1922 M	aryland	
	and and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	Marylan -f ahow fied at	to	Maryland Washin	gton	На	gerstown			1 ☑XYes 2 ☐ No		
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?	
	23a c	rai	421 West Church			2174			USA		
2	s 1 and 2 should be filed within 72 hours after death with the Maryland If Hailth and Mental Hygiene. If Hailth and Mental Hygiene. If The Maryland other then "naturel", or Items 23s or 28s-f show other traumatic event, the Mardical Examination and be notified at	y Funerai	11. Marital Status 1 Never Married 2 Marned	12. Was Decedent E Armed Forces? 1 🛣 Yes 2 □ N If Yes, Give		I. Was Decedent of Hispi If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No 3	anic Origin? (Spe Mexican, Puerto I Specify:	Rican, etc.)	14. Race - Am Black, Wh Specify:		
Ś	2 hours	ted by	3 ₩ Widowed 4 Divorced 15. Decedent's E	Year or Dates:	16a. Dec	edent's Usual Occupation	on , , ,	1	6b. Kind of Busines:	s/Industry	
2	thin 72 e. m. n.	Completed	(Specify only highest gra	College (1-4or 5	+)	edent's Usual Occupation we kind of work done during DO NOT use retired)		ng			
7	filed with Hygiene. other ther ant, the N		10	0	tool	and dye ma		(First, Middle, M	upholster	:y	
=	ould be fi Mental H arkad ot atic evar	Ве	17. Father's Name (First, Middle, Last, Elden Wilbert En			10		Alice Pa			
<u></u>	2 should be and Mental is marked sumatic ev	ᅀ	19a. Informant's Name/Relationship (19b. Ma	iling Address (Street and				Zip Code)	
	1 and 2 Health a tem 27 is		Carol Wagaman -	daughter	111	2 Moller Av	e., Hage	rstown,	Md. 21740)	
บ์ ว	of He of He of or other		20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dis	position (Name of rematory or other place)	1		Oc. Location - City o	r Town, State	
<u> </u>	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		4 ☐ Donation 5 ☐ Other (Special	ý) -	_ I	awn Mem. Pa	1			, Maryland	
0	permit. Departrimports any inj		21. Signature of Funeral Service Lice	MM	mi O	22. Name and Address of 415 E. Wil				1. 21740	
			23a. Part1. Enter the disease, or corp. shock, or heart failure. List only	plications that caused	the death. Do not e					Approximate Interval 8etween	
,	Physician		Immediate Cause (Final disease or condition	Con	onavy	artery	disea	se		Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of)	121 11 h	ing fori				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	consequence of):	- 1	10-				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pres	s plus for	ry ingu	fficten	cy			
Š	e exer	Exe	resulting in death) Last	Due to (or as a	a consequence of):	A low	0345	(
00/00	ficate be executed physicien and is the burial-transit	edical	•	d. / u	1 moves	7					
XOC	death certifi ettending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of d	elivery	
0	The law requires that the death certificate be executed are has been signed by the ettending physicien and age 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		B ☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year	
ر د	hat the id by t	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause given	in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
ds,	uires t signe Id be c		Trangvien		emica			1 □ Ye	s 2 □ No 3 □ F	Probably 4 Unknown	
ecords	s beer shou	Completed	Hypest-	ension				24a. Was ar	24b. Were	autopsy findings available ocompletion of cause of	
ב ב	The la	mo						autopsy perform	red? death?	s 2 No	
NI S	cien: ertifica	Be	25. Was case referred to medical examiner?					(Check only one	9)		
5	Physic this o	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpat ry 28b. Time		4 Nursing Ho		nce 6 Other (Sp w injury occurred	ecity)	
0	ding th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	Year) Injur	y Work?	s 2 No	200. 200000			
DIVISION	Atten actor by the	Certification:	3 Suicide 6 Could not to		ury - At home, farm,	street, factory, office		28f. Location (Str City or Town	reet and Number or I	Rural Route Number,	
5	ital or ral Dir lled in							·			
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifying P (Check only one) Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the time, investigation, in my opin	date and place, ion, death occurr	and due to the ca ed at the time, da	use(s) and manner at the and place, and di	as stated. ue to the cause(s)	
	To the within To the comple	Me	29b. Signalure and title of certifier			29c. License r		_	9d. Date signed (Mor		
)			1 you		· i en-	0. 100	0411)(may.	11001	
51	H-5+1		30. Name and address of person who	COPPEC	es, uni	De, Print)	par ce	surt, l	tagevator	in, MD 2174	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 9 2	32. Registra	ar's Signature	berte					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** рΜ Jewell Tiee Estes 2007 Mav 2 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Bottom Road 7. Age (In yrs. last birthday) Germantown
If Under 1 Year | If Under 24 Hrs. Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 € X Yrs. Director 242-05-2590 87 Dec. 24, 1919 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐Yes 2 ☑ No Examiner must be notified Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 death with items 23a 31 Bryants Nursery Road 20905 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married b Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Federal Government Pages 1 and 2 should be filed nent of Health and Mental Hygi int: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willis Cornelius Linville Lillian Julia Alburt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Faulk/ Son 31 Bryants Nursery Road, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) May Date 7 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2007 Crownsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spr. Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed?

1 Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Daughter's 1 ☐ Yes 2 ☑ No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Residence Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: in by the 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760

hours

2

the within To the

6 ☐ Could not be 4 Homicide

0 4 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

D64615

29d. Date signed (Month, Day, Year)

May 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D 1355 Piccard Drive, #100, Rockville, MD 20850

State Registrar

Medical

29a. Certifier

			1 - For State Registrer	State of Ma		d / Depa		t of H	ealth a		ental Hyg		07	162	39	
r		1. Decedent's Name (First, Middle, Last)									2. Date of Dea	ıth		3. Time o	of Death	
М	° Physici /Medic		COLEY FERGUSON								Month 5	Day 02	O 7		PM	
8	Examin		4a. Facility Name (If not institution, give s		4b. City,	Town, or	Location of	of Death		4c. C	ounty of De	ath				
the.			Cresent City Nursing Home						le			Prince Georges				
类	, Funeral		5. Social Security Number 6. Sex	CM OFF		ast birthday)	If Under Months	1 Year Days	if Under : Hours	24 Hrs. Min.	8. Date of Birth	Year)	9.8	irthplace (State Country)	or Foreign	
ı.	Director		249-44-3942	AM ZUF	73	Yrs.	J. J. J. J. J. J. J. J. J. J. J. J. J. J	,0			June 19	, 19	33 Soi	uth Caro	olina	
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside 0	City Limits	
	sho	'n	DC		_	ashing									s 2 No	
	28a-1	ect	10e, Street and Number									10a Citiza	en of What	Country?		
	with E or	D.	1825 Maryland Ave	N F #2	3			2000	12					oodiniy:		
	ns 23	Funeral Director				S. 13.1				gin? (Spe	cify Yes or No-		USA 14. Race - American Indian,			
10	r Iter	Fu	1 Never Married 2 Married	1 ☐ Yes 2 2 1	1 ☐ Yes 2 🔁 No If Yes, Give					, Puèrto	cify Yes or No- Rican, etc.)		Black, White, etc.			
8	al'. o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2 LXI No	Specify:			5	Specify:	Black		
2-0	72 hc natur	Completed	15. Decedent's Edu (Specify only highest grade	t's Education 16a. De				l Occupa	ation	t of worki	na	16b. Kin	Kind of Business/Industry			
7	ithin Ben.	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of wor DO NOT us)							
2	ba filed within 72 hours atter death with the Maryland ital Hygiene. d other than "natural" or Items 23s or 28s-1 show event, the Medical Examinat must be notified at	Co	9th			Bar	Porte	r					flower Hotel			
and	ba fi	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden S	iumame)			
3	1 Mer narke	T ₀	unknown	Deint		405 M-10-			Lulu				T 01 .	7-0-11		
Maryland 21215-0036	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Ty)			1825	Maryl	and	Ave.	NE #	Route Number	r, City or	rown, State	, ZIP Code)		
	permit. Pages 1 and 2 should ba filed within 72 hours after death with tha Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or ftems 23s or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at Once.		Grace Jackson/Frie 20a. Method of Disposition	II u	20b. P	Washi lace of Dispo	sition (Nan	ne of		1002	ate	20c. Loc	ation - City o	or Town, State		
nor	ages int of t: If it		1 Burial 2 SCremation 3 R 4 Donation 5 Other (Specify)	emoval from State		emetery, crer	-									
Baltimore,	artme ortan injur		21. Signature of Funeral Service License	90	Met	ropol:	Ltan (2. Name an				-07	Атех	andria	a, va.		
B	permi Depa Impo any it		> SIPILIAN	1400		M	larsha	11's	fune	eral	Home, I Washing	Inc.	D C	20011		
	- •		23a. Party. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death	n. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arr	est,	D.C.	Approxima Interval Be	ite	
	Physician		Immediate Cause (Final										Onset and	Death		
	/Medical		disease or condition resulting in death)	BACTERE MIA Due to (or as a consequence of):												
ÿ	Examiner		Sequentially list conditions	CIRRHOSIS												
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):												
	ecuta and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	DEMENTIA Due to (or as a consequence of):												
760,	te be executad ysician and te burial-transit	cai E		COLON			0									
687				LOLON	,	HIVE										
×	certif Iding Ise as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	c. If yes, outcome of pregnancy						23d. Date of			f delivery		
Box	death atter	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	_		Ectopic pro Other (sp					1	Month	Day	Year	
0	t the by the ache	hys	9 Unknown	m												
S,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions con		ut not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute	to the cause of	death?	
ä	w require been sly should b	ed	SEIZURE DISON	LDER							1 🗆 Yı	es 2💢	No 3□!	Probably 4 🗌]Unknown	
Vital Records,	law r as be 2 sh	Completed	CONGESTIVE HE	ART FA	Lule	5					24a. Was a			autopsy findings o completion of		
Œ.	The law cate has page 2:	Con	*								perform	med?	death'	? as 2□No		
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					112.0			(Check only or					
of	Physic this of al dire	7°	1 162 2 10	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol							me 5 Residence 6 Other (Specify)					
UC	ding Physician: h. After this certific funeral director,	ion	1 Natural 5 □ Pending (Month, Day Year) Injury Work?								28d. Describe how injury occurred					
Division	Attending Physician: r death. sctor: After this certifici	lical	2 Accident investigation M 1 Yes 2 N 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office								28f. Location (S	treet and	and Number or Rural Route Number,			
<u>S</u>	after Dire	Certification:	4 Homicide determined	determined building, etc. (Specify)							City or Town, State)					
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 12 Certifying Physic (Check only one)	sician: To the best of the control of the basis of and manner sta	examinat	wledge, death tion and/or in	h occurred a vestigation,	at the tim in my op	e, date and pinion, deal	d place, a th occurre	and due to the co	ause(s) a late and p	nd manner place, and d	as stated. ue to the cause((s)	
	Fo the within Fo the	Me	29b. Signature and title of certifier						number					nth, Day, Year)		
)	- 2 - 0) I MM.									05/05/2007 LS MARYLAND ZOTY8				
)	(2)		30. Name and address of person who co	mpleted cause of de	eath (Item		Print)				ŀ					
(THU NGUYEN, MI	0.0.	01	BRA	NCH	AV	ENLE	TEN	PLE HIL	LS A	1ARYL	AND ZOT	18	
*	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 7 2007	32. Registra	ar's Sign	de										

DHMH 17 Rev 1/2001

1405

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Montgomery

Black, White, etc.

White

Maryland

Physician /Medical Examiner

May 2, 2007 KERIN FERNAND 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-22-2006 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 XF 212-77-2575 10 Director 8 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 19707 Maycrest Way 20876 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married o. Yes 2 No Specify: Salvadoran Saltimore, Maryland 21215-0036 à Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry uth and Mental Hygiene. 27 Is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) none 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be Jose Omar Fernandez 19a. Informant's Name/Relationship (Type, Print) Yeni Quintanilla/mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Family Cemetery 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-13-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Ogcon. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Examiner Trisomy 13 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary Artery Stenosis physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Agenesis Corpus Callosum page 2 should 24a. Was an certificate has autop*s*y performed? /es 2**X** No 1∐ Yes 25. Was case referred to medical examiner?
1 X Yes 2 No director, 26. Place of Death (Check only one) Be Hospital: 1X Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOOLE4502 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian CARPENTER Medical Center Drive, Rockville Mi) 20850 9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 7 2007

none 18. Mother's Name (First, Middle, Majden Surname) Yeni Quintanilla 19b_Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19707 Maycrest Way Germantown, Maryland, 20876 20c. Location - City or Town, State San Miguel, El Salvador 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 14th Street, N.W. Washington, D.C. 20010 Approximate Interval Between Onset and Death 10 hours 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Catherine Monica Foy May 3, 2007 3:45 A^{M} /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth (Month, Day, Year) if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** New York Days Hours 1 □ M 2 🔀 F 71 Yrs. July 6, 1935 117-26-5532 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ones. 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2X No MD Prince Frederick Calvert Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20678 115 Allnut Court Apt 706 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No ģ 3 ☐ Widowed 4 🙀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary P.G. County Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McLoughlin Thomas Fov Catherine ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12017 Steven Lane Dunkirk, MD Kathy Knight (daughter) May 8 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Southern Mem. Grdns. 2007 4 Donation 5 Other (Specify) Dunkirk, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee Cary J. Goff Owings, MD 20736 8125 Southern Maryland Blvd. 23a. Pail 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days disease or condition resulting in death) /Medical Due to (or as a conseque e of): Examiner Volva eca Sequentially list conditions, if any leading to in including cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Day Year 5 ☐ Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 1□ Yes 21110 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Mann of Death in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6039 0 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK, Tabe HOSPITMO 31. Date filed (Month, Day, Year) 32. Registr State

Registrar

4 2007

MAY

State of Maryland / Department of Health and Mental Hygiene 2 16242 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 05 01 2007 1848 JOSEPH FEMI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 **3**€M 2 □ F Maryland Director June 08, 1928 212-24-1616 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County sa or 28a-f show t be notified at 10a. State 1 ☐ Yes 2 M No Director Frostburg Allegany Maryland filed within 72 hours after death with the Hygiene. Hygiene. ther than "natural", or Items 23a or 28a-10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 16718 Nazzerano Lane, N.W. an "natural", or Items 23a Medical Examiner must t 21532
13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0036 Specify: ğ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the mechanic brick manufacturer and Mental Hygie Is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosie Bisigiano ပ Nazzereno Femi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-Frostburg Maryland 16718 Nazzerano Lane Anna Lee Femi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Savage Maryland 4 ☐ Donation 5 ☐ Other (Specify) May 04, 2007 Saint Patrick's Cemetery 22, Name and Address of Facility 21. Signature of Funeral Service Licenses Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONGESTIVE about bear Physician /Medical Due to (or as a consequence of): Examiner CORONARU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p for use as 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t Division or Vital Records. 3BSTRUETIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Y Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) patient 28a. Date of Injury 2 ER/Outpatient 3 DOA ava No 1 ☐ Yes Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

■ Funeral Director: A

pletely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 016907 MAY 02 2007 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. Harri T SibHU 925 Bishop WALSH Cumberland, ND 21502 nas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 150 4 P Registrar 0 3 2007

State of Maryland / Department of Health and Mental Hygiene 16243 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ALMIRA P. FRAMPTON APRIL 2007 12:35AM^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT HOSPICE HOUSE EASTON TALBOT 8. Date of Birth (Month, Day, Year)
APR. 13, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Yrs 215-20-2520 MARYLAND 1926 Director APR. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Madical Examiner must be notified at Director 1 ☐ Yes 2√ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 10894 OLD CORDOVA ROAD 21601 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after ☐Yes 2 XNo fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 XWidowed 4 ☐ Divorced "natural', Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry t and 2 should be filed within dealth and Mental Hygiene. sm 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SALES CLERK RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROY PERRY ပ HILDA HOPKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 JAMES PERRY/BROTHER 29641 DOVER ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages I Department of H Important: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 5/5/2007 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 Woseph m. Ostrough C.F. 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each, line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Dear Immediate Cause (Final Meta Physician TN disease or condition resulting in death) 100 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to machine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for Yes 2□No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Wiknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Machine (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes & No P 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 🗋 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifing 29d. Date signed (Month, Day, Year) D2575 4-30-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE., EASTON, MD 21601 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 0355M 200 BESSIE G. FISHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial Hospital at Easton Faston Talbo If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 17 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Months Hours 1 □ M 2**X**) F NEW YORK 89 Director 216-14-2126 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10436 LONGWOODS ROAD 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ۵ م Specify. WHITE 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CAFETERIA WORKER PUBLIC SCHOOL SYSTEM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD BODELL NELLIE VAN DERPANE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES FISHER/SON 3662 CHOPTANK ROAD, PRESTON, MARYLAND 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 DRemoval from State 4 □ Donation 5 □ Other (Specify) WOODLAWN MEMORIAL PARK 5/4/2007 EASTON, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee C.F.S.P FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph Ustrousk. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6BSTRUCTION SMALL BOWER Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and stranger the burial-tranger Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: n 24 hours after des ne Funeral Directo nletely filled in by tt completely

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a. Certifier

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

BOTSIS M.D. 219 S. WASHINGTON ST EASTON, MD 21601 31. Date filed (Month, Day,

State Registrar

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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of partifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY McCLAIN, M.D. 321 PRINCE GEORGES ST., LAUREL, MD. 20707	Sio	tendi eath. tor: A the fu	cati	2 ☐ Accident investigati				Yes 2 □ No	006 1	(04	- A and Alumbas as Dumi Pauto Alumbas			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 12:42 A^M James 2 2007 Goodson May Roy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 3 M 2 □ F 91 Yrs. 579-44-1616 West Virginia Director Jan. 6, 1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2x No Directo Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number be I permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bonce. 5955 Quinn Orchard Road, #124 21704 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ¬Yes 2 □ No If Yes, Give 1943-46 Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Physician/Surgeon Medical 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be James W. Goodson Anna Mae Jarrett မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5955 Quinn Orchard Road, #124, Frederick, MD 21704 et of Disposition (Name of 2000) Date 2000, Location - City or Town, State Rita T. Goodson/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5, May 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Meumonia robable /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. | ned by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. s been signe à ensive Ence Phalo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bfiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Hospital or Attending Physician:

s after dec. filled in by within 24 hours at To the Funeral C completely filled

Medical

29a, Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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and manner stated.

MD

egistrar's Signature

29b. Signature and title of certifier

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0060417

DV

29d. Date signed (Month, Day, Year)

MD 21702

Frederick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** CHARLES RUDOLPH 05 12 2007 1515 GREEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1√2 M 2 ☐ F Feb 4, 217-24-8994 76 1931 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 114 Independence Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10 XYes 2 No If Yes, Give Year or Dates: 50-53 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "r any injury or other traumatic event, the Med once. r than " Elementary/Secondary (0-12) College (1-4or 5+) Dock Worker Transport Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Green Lillian Rebecca (Madison) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mark A. Green 11 Independence St., Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans May 16, 2007 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensee 404 Decatur St., Cumberland, MD 21502 NO Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as a complex of the compl o used the death. Do net each line. g, such as cardiac or respiratory arrest nter the mode of av Immediate Cause (Final RECTIC **Physician** disease or condition resulting in death) EM /Medical (or as a consequence of): Examiner 1 PBRICE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying sause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 00 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has e 2 autopsy performe certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Inpatient 1 ☐ Yes 2/2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 은 this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury (Month, Day Year) Natural 2 ☐ Accident 5 Pending investigation within 24 hours after commercial of the Funeral Director; Aft 1 □ Yes 2 □ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

3/10A

HRS State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

4

< 902 Se 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:07 P M 28. 2007 April JOHN HENRY HINDSMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1**X** M 2 □ F 81 253-30-6289 October 26, 1925 VillaRica, GA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑ Yes 2 ☐ No Directo Maryland Prince Georges SUITLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2537 Fairhill Drive 20746 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 X Yes 2 No 1/44 If Yes, Give Year or Dates: 7/75 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black ş 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilhur Hindsman Essie Mae Poole ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2537 Fairhill Drive Suitland, Maryland 20746 Johnnie Hindsman / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chelten Hills Cem. 05-05-07 Philadelphia, PA 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Md. 2074 21. Signature of Funeral Service Lice see Forestville, Md. 20747 Dang 40105 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISCHEMIC LEFT FOOT Unknown disease or condition resulting in death) Due to (or as a consequence of): SEPSI) 44K LOW, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Kear Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy perform 1∐ Yes 2⊠ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner The law requires that the death certificate be executed

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

burial-trar physician the use as the s been signed by the should be detached page 2 director Certification: To this funeral To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A filled in by

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: Medical completely State Registrar

5 Pending investigation

6 Could not be determined

- Fale M.D

29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Are Sit 3-41 silver spring MD 20902 FAR AMIFAR M.O.

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MAY 0 4 2007

29b. Signature and title of certifier

27. Manner of Death

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

1 Natural

32. Registrar's Signature 1.

28a. Date of Injury (Month, Day Year)

and manner stated

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** April 26° 2007° ar 5:51р. м Jacob Holoman, Jr. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges. Clinton SUNSHINE HOME CARE SERVICES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | May 23,1913 6. Sex 1 M 2 F 9. Birthplace (State or Foreign Country) VA. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 579 01 2.619 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23a or 28a-f ehow The Medical Examiner must be notified at MD. Prince Georges Clinton YE Yes 2 □ No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 12900 Marcia Place USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
sant: If Items 27 is marked other then "natural, or Iteme 23.
uty or other fraumetic event, it a Medical Exartina mustury or other fraumetic event, it a Medical Exartina must 12. Was Decedent Ever in U.S. Amed Forces? 14∑Yes 2☐No If Yes, Give Year or Dates: 46-47 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 years 12 years Chef Naval Operator Navy Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Malissa Hicks Jacob Holoman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7430 8th. St, N.W. Wash., D.C. 20012 Virene H. Langford / Sister 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny Injury or once. Gilfield Church 5/5/2007 Ivor, VA. 4 ☐ Donation 5 ☐ Other (Specify) and Address of Facility JOHN T. RHINES FUNERAL HOME 21. Signature of Funeral Service Licensee 3015 12th ST, N.E. WASH., D.C. 20017 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conse Examiner attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical JF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Tyes within 24 hours after death.

To the Funaral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death DOROTHY HEIGH Dav **Physician** 2007 APRIL 30. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3516 PINEVALE AVE. FORESTVILLE PRINGE **GEORGES** FORESTVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 1 F Director 577-78-6764 March 26,1955 Washington, D.C. Usual Residence of Decedent with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Pringe Georges FORESTVILLE Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code an "natural", or items 23a or Medical Examiner must be PINEVALE 3516 AVE., Funeral 20747 filed within 72 hours after death UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Day Care Provider Private . Pages 1 and 2 should be filed w tment of Health and Mental Hygien tant: If item 27 Is marked other ti lury or other traumatic event, th unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernice Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin Heigh-Husband 3516 Pinevale Ave., Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Resurrection May 4,2007 Clinton, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lig 5538 Marlboro Pike 22. Name and Address of Facility Pope Funeral Homes PA Forestville, MD. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) Physician Left Renal Cell Carcinoma, Stage IV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an ate has page 2 s autopsy 1∏ Yes 2 X No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 18 Residence 6 Other (Specify) 2<mark>₹</mark> No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1.2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR4

State Registrar Kai Yin Yeng
31. Date filed (Month, Day, Year)
HAY 0 4 2007

8926 Woodyard Rd. #201 Clinton, Md. 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D14730

May 3, 2007

			For State Registrar	State of M	arylan		artmen rtificat			and M	-	giene Reg. No.	007	162	52
	Physicia	%: 30	1. Decedent's Name (First, Middle,								2. Date of De	Day	th Yea	3. Time of 0	
	/Medic		ROBERT HAYES								April 28 2007 3.				P M
٠,	Examin	er ~	PRINCE GEORGE'S HOSPITAL CHEVERLY									4c. County of Death PRINCE GEORGE 'S			
Jên:	Funeral Director		154-18-1179	. Sex 7. Ag 1⊠M 2□F	91	iast birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da NOV 6	th y, Year) 1915		Birthplace (State or Country) NEW JERSE	
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	or 28g	Director	10e. Street and Number				10f. Zig					10g. Citi	zen of What		
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	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces?)	.S. 13.	Was Dece If Yes, spe	dent of His offy Cubar	spanic Orig n, Mexican	gin? (Spe 1, Puerto I	cify Yes or No Rican, etc.))-	14. Race - A Black, W	merican Indian, 'hite, etc.	
39	itied within 72 hours after death with the Maryland Hygiene. yther than "natural", or Itema 23a or 28a-f show yit, the Macical Examinat must be notilliad at	by	1 ऒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Give			1 🗆 Yes	2 X No	Specify:				Specify:	BLACK	
- 2	72 hou	ted	15. Decedent's (Specify only highest		Education 16a. Dece			al Occupa	ition luring mosi	t of worku	na	16b. Ki	nd of Busine	ss/Industry	
21215-0036	ne.	Completed	Elementary/Secondary (0-12)	Secondary (0-12) College (1-4or			DO NOT U K DRI	se retired,)		.3	PE	RIVATE		
22	Hygier Hygier Ther th	CO	12th 17. Father's Name (First, Middle, La	ist)		IRUCI	K DKI	VEK	18. Mothe	er's Name	(First, Middle,				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itema 23a or 28a-1 show any injury or other traumatic avent, the Modical Examinating the notilized at an	To Be	JAMES HAYES							MIN	NIE FIS	SHER			
	and 2 sh salth and n 27 ts m er traum		19a. Informant's Name/Relationship RUBY WISEMAN/FR							VASHING					
Baltimore,	Pages 1. nent of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		osition (Name of ematory or other place) LE CREMATORY 5/3/2			2007		: Location - City or Town, State I VERDALE, MARYLAND					
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3	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	ty one cause on each i	ine.						r respiratory a	rrest,		Approximate Interval Betw Onset and D	/een
26 1	/Medical Examiner		Due to (or as a consequence of):									DAY	/ S		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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P.O. Box	Attending Physician: The law requires that the death certifica refeath. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the stream of	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B□Ectopic pregnancy □ Other (specify)					2	23d. Date of delivery Month Day Y		ear		
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Vita	certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ion: To	1 Yes 20 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	28b. Time o Injury		f 28c. Injury at Work?				ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
ivisio	or Attenditer death	Certification:	Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	be an Blood of Injury At home form about factors office						28f. Location (Street and Number or Rural Route Number, City or Town, State)				ρθ <i>Γ</i> ,	
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in		29a. Certifier (Check only 2 Medical E												
	the F the F the F	Medical	one) 29b. Signature and title of certifier	and manner si	tated.									onth, Day, Year)	
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n	(4)		30. Name and address of person w	no completed cause of	death (Iter	n 23a) (Type,	Print)			/	0 0		01	1 11	0
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Physicia /Medica Examine

Funeral Director

	Please											
	For	State of Ma	•	•			and M	1ental Hy	gien	e	0 7	ICOFO
	1 State Registrar			Certific	ate of I	Death			Reg. N	6/ U	U/	16233
	1. Decedent's Name (First, Middle, La	ist)						Date of De Month		ay	Year	3. Time of Death
ï	Agnes	Carroll	Hil	lgenb	erg			May 2		2007		2:55 P M
r	4a. Facility Name (If not institution, giv				City, Town, or				4	c. County		
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	5. Social Security Number 6. S	sex //. Age 1 □ M 21√2 F	(In yrs. last birt	Yrs. Mon		Hours	Min.	8. Date of Bir (Month, Da 07-25	пп ay, Yea	r)	Cou	place (State or Foreign ntry) h., D.C.
	579-50-0332 Usual Residence of Decedent	••	68					07-25	-193	00	was	11., D.C.
	10a. State 10b. County		10c. City, Towr	or Location								10d. Inside City Limits
jo	MD Calvert			Che	esapea	ke Be	ach					1 X Yes 2 □ No
ě	10e. Street and Number			10f	. Zip Code				10g. 0	Citizen of V	What Cou	intry?
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auer Tuer	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was D	ecedent of H specify Cuba	lispanic Ori an, Mexicar	igin? (Spento	ecify Yes or No Rican, etc.)	0-		e - Ameri k, White	can Indian, . etc.
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an a	15. Decedent's Education (Specify only highest grades)	ade completed)		(Give kind o	f work done of OT use retired	during mos	t of work	ing	160.	Kind of Bu	1211622/II	idustry
ompleted	Elementary/Secondary (0-12)	College (1-4or 5-		atist		-7			F∈	edera	1 Go	vernment
ב כ	17. Father's Name (First, Middle, Last	")				18. Mothe	er's Name	e (First, Middle	, Maide	en Surnam	7e)	
0	Louis	C	arroll			Mar	У				Ма	ttingly
	19a. Informant's Name/Relationship ((Type. Print)	19b.	. Mailing Add	lress (Street	and Numbe	er or Rur	al Route Numb	er, City	or Town,	State, Zi	p Code)
	Lori A. Hilgenber	g, daughte	r 13	52 Rec	dwood	Circl	e, L	aPlata	, MI	20	646	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Romoval from State	20b. Place of cemeter	Disposition ry, crematory	(Name of or other plac	ce)	[Date	20c.	Location -	City or T	own, State
	4 □ Donation 5 □ Other (Special		Ft. Li	.ncoln	Cemet	ery	05-0	7-07	Bre	entwo	od,	MD
	21. Signature of Funeral Service Lice	nsee		22. Nam	e and Addre	ss of Facili	ty R	ausch 1	Fune	ral	Home	, P.A.
	Willom K.	(you		832	5 Mt.	Harmo	ny I	n., Ow	ings	MD	_207	36
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do r e.	not enter the	mode of dyin	ng, such as	cardiac (_				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a	Non	enj	0	Ne	ny	—	se	esl		onesi and boarn
	resulting in death)	Due to (or as a	consequence	of):								
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8 State Registrar

110 Hospital Rd., Ste. 305, Prince Frederick, MD 20678 Mukesh Mathur, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registra Signature 2007 MAY

07-03247 John H. Hough, Jr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 16254

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O.C.M.E. April 29, 2007		To the within	To th	edi	1 1			and man	ner stated	d									29d. Date	signed	(Month, Day, Year)	
(James who completed cause of death (Item 23a)				Σ	29b. Signature a	and title of Ce	eruner	1.	\cap				1	Ο.	C.M.E.				April 29	, 200	7	
too styres and address of person who completed cause of death (Item 23a)					114	Int	mak	edr	1				1									
			,				erson wh	no completed	d cause of	f death (It	tem 23a)	Pe	nn Stre	et. Ba	altimore	, MD 2	1201					
Later Later Later Will. And Street Street Later Street La	10-	HO	4	†								, e	Out									
State 31. Date filed (Month, Day, Year) 3 2007 32. Resistrar's Signature	М			State	31. Date filed (A	Ionth Day	(ear) 3	2007	32. Regist	rar's Sigr	lature		Com	K)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMONTH L **Physician** 953 PM 200-0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOSPINAL SALTIMIRE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2X F Yrs. 79 Dec. 2, Director 223-38-9659 1927 Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 ☑ No Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? ms 23a or 3 USA 645 Lakeland Road South 21146 death Funeral Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural" or items.
My Injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Herman Glenn Amy North 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Thomas E. Hunt/Husband 645 Lakeland Road South Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 5, 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Fairview Cemetery Roanoke, VA 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final disease or condition resulting in death) INPHOMA Physician recks /Medical Examiner Sequentially list conditions, if any, leading to immediate caus. Enter or critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed g physician and as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 1 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) s af er dea....al Director: After 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral L 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiet Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 3 2007

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Registrar's Signature

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State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

			1 – For State Registrar	State of M	aryland /	-	artment of H			ene g. No. 0 0 7	1 16257
ı			Decedent's Name (First, Middle, La.	st)					2. Date of Death	1	3. Time of Death
	Physici /Medio		Norman Louis 8	lughes					4 ^{onth}	2 ^{pay} 200	7 1:50p M
	Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death		4c. County of D	eath
			Carroll Hospid				Westmin			Carro	
П	Funeral Director		5. Social Security Number 6. S 219-40-6699 2	·	je (In yrs. last 65	birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year) 9.	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	•					01-29	-1942 B	altimore, Md
	yian how		10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits
	e Ma	ctor	Md Talbot		Bozn	nan					1 ☐ Yes 2 No
	를 5 6	Dire	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
	23a	rai	22746 Almost 1				2161			USA	
21215-0036	be filed within 72 hours efter death with the Maryland niel Hygiene. ed other then "neturel", or Iteme 23s or 28s-f ehow event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		umencan Indian, Vhite, etc. White
5-0	72 hg netur	eted	15. Decedent's Ed (Specify only highest gra	lucation	_	6a. Dece	dent's Usual Occupa	ation	tina 1	6b. Kind of Busine	ess/Industry
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired)	9	Milita	ry
	Hygi Hygi nt,		12 years 17. Father's Name (First, Middle, Last,				U.S. Ar		e (First, Middle, M	laiden Sumame)	
Maryland	2 should be to and Mentel I e marked or eumatic eve	To Be	Noble Hughes						Schiess	,	
J.	a 1 and 2 should I f Heelth end Men Item 27 le marke other treumetic	F	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailir	ng Address (Street a				e, Zip Code)
	and 2 seeth er n 27 le		Sharon Bryan	niece)	16	83	Hook Rd	. Westm	inster,	Md. 21	157
altimore,	of He of He roth		20a. Method of Disposition 1X□ Bunal 2 □ Cremation 3 □	Domaral from State	como	of Dispo	sition (Name of natory or other place			Oc. Location - City	
Ë	Pegea ment of a ant: If Its ury or o		'4 □Donetion 5 □ Other (Specif		Neav	itt	Cemete	ry 5-1	-2007 N	eavitt,	Md.
Ball	permit. Peges 1 and 2 Department of Heelth e Important: If Item 27 le any injury or other tree		21. Signature of Funeral Service Licer	1/ 1/	lus	R	. Carro	ll Hurl			
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	olications that cause one cause on each I	d the death. D	o not ent	er the mode of dyin	g, such as cardiac	or respiratory erre	st,	Interval Between
	Physician		Immediate Cause (Final disease or condition	. (11	115	C	Mor				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):					7000
	=2.001111101)r	Sequentially list conditions,	b. Due to (or as	a consequenc	e off.					
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 43	a consequent	20 01).					
Ć,	execun and iai-tre	Exa	that initiated events resulting in death) Last	Due to (or as	a consequenc	ce of):					
8760,	cete be executed ohysicien and the burial-trensit	dicai	•	d							
9	ng ph	Med	IF FEMALE:	62							
P.O. Box	The lew requires that the death certificete be executed tte has been signed by the ettending physicien and begee 2 should be deteched for use es the burial-trensit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)		-	23d. Date of Month	delivery Day Year
	res thet the igned by be detected		Part It. Other significant conditions of	ontributing to death t	out not resultin	g in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ord	w require been sig should t	ted							1 Ye	s 2□No 3□	Probably 4 Unknown
Vital Records,	slewr hasbe e 2sh	Completed by							24a. Was an autopsy	24b. Were prior	autopsy findings available to completion of cause of
aiF									perform 1 ☐ Yes 2	death	res 2□No
₹ Z	Physicien: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:			Othe	00	h (Check only one		Hassine
oţ	£ = <u>F</u>	-	1 ☐ Yes 2 ☑ No 27. Manney of Death	28a. Date of Inju		Outpatien o. Time of	1 30 DOX	4 - Nuising no	28d. Describe ho	nce 6 Softher (Softher)	Specily) HOSPICE
on	Attending ir deeth.	atlo	1 Adatural 5 Pending 2 Accident investigation		y Year)	Injury		(? /es 2 □ No			
Division	after des Birecto d in by th	Certification;	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, ic. (Specify)	, farm, str	eet, factory, office		28f. Location (Str. City or Town,		r Rural Route Number,
	To the Hospital or Attend within 24 hours after deeth To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and manner st	f examination	ige, deatl and/or in	n occurred at the tim restigation, in my op	ie, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To th within To th campi	Me	29b. Signature and title of certifier		,		29c_License	number	29	d. Date signed (M	onth, Day, Year)
			· Omme	m			US	788/	4	7/30/0	57
	6+VA		30. Name and address of person who	completed cause of	death (Item 23	a) (Type,	Print)		_1	1	1
	Sta	to	David Smith, N 31. Date filed (Month Day, Year)	32. Regist	5 Pint	ail	Dr., Ea	aston, A	4d. 2160	01	
	Registr		31. Date filed (Month Day, Year) APR 3 0 2		w #		الكام				

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1851 Apn 25 Thomas 2007 Glen Holden, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Dorchester ambrida orchester General Opital If Under 1 Year | If Under 24 Us. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 10 M 20 F Yrs. Director 221-16-2968 Maryland 02-03-1931 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County other then "natural", or Itama 23a or 28a-f ehow rent, the Medical Examiner must be notified at 1 XYes 2 No Maryland Dorchester Cambridge Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 419 Willis Street 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify <u>^</u> 3 ☐Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 8 Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be thent of Health and Mental marked (Archie Holden Emma Lawes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 99 it of Health a if item 27 is or other trai Carolyn A. Holden / Daughter 2 Running Pine Rd., Granby, CT 06035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If eny injury o 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 05-01-2007 Dover, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bennie Smith Funeral Home
524 Race Street, Cambridge, Maryland 21613
Acoroximate permit. Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien a s the burial-Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 4 ☑ Unknown 3 Probably 1 ☐ Yes 2 ☐ No been si Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s page this certificate 1□ Yes 1 🗌 Yes 2 No 2 1 No 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes ၉ 1 Inpatient 2 X ER/Outpatient 3 DDA After the 27. Manner of Death 1 Matural 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 2 b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funerei Direct completely filled in by 4 | Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BYRN STREET, CAMBRIDGE AUHTER 503 31. Date filed (Month (legistrar's Signature State 2007

Registrar

Holden, GIPKI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 16259

		or State			$C\epsilon$	ertificate	of i	Death					Reg. No).		3. Time of Death
ysician/		istrar Decedent's Name (First, Midd	ile,Last)									Date of De Month	Dav	Year		1111 hrs
xamine	1	Mark Edwa	rd H	opko						,		May 4, 2	1.	4c. County of	Death	
	4a.	Facility Name (if not instituti	on, give stre	et and numb	per)		41	b. City, Tow Monrovi		ocation of	Deam		- 1	Frederick		
	Н	3835 Chaucer Court								If I Indos	24Hrs	8 Date of F	Birth (M	M/DD/YYYY)	9. Birt	nplace (State or
Funeral	5.	Social Security Number	6. Sex	7.	Age (In yrs	. last birthda	y)	If Under '	Days	Hours	Min.				LOICIA	^{n untry)} Mary land
Director	2	13-96-4219	1 X M	2 F	40		Yrs.					June	7,	1966		Mary rand
	Us	ual Residence of Decedent													_	10d. Inside City Limits
any		a. State 10b. Count	<i>y</i>		10c. Ci	ity, Town or L	.ocau	on								1 Yes 2 X No
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eath with the Maryland items 23a or 28a-f show ust he notified at once.		3835 Chaucer	Cour	t					177		0.1.0	'/ . V	Nio	U.S.		ican Indian, Black,
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item item	L Turera	Never Married 2 X	1 1	Yes	2 X No	o		Yes 2						Specify:	Wh	ite
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atura atura		15. Decedent's Education (S				16a. De	ing m	ost of work	ing life.	DO NOT	use retir	ed)	l	Monte	ome	ry County
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or tha	ᇍᆫ								-1	18.Mother	s Name	(First, Midd	le, Mai	den Surname	e)	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		7. Father's Name (First, Midd Edward Jo	ohn F	Iopko					- 1		arsh					
121 d be fi ental arkec	B B	ga. Informant's Name/Relation		_		19b.	Mailin	g Address	(Stree	t and Num	ber or F	Rural Route	Numbe	r, City or To	vn, Stat	e, Zip Code)
Should by is man	₽∏	Cheryl A. Ho	pko -	Wife							t, M	lonrov	ia,	Mary.	land	21770
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic page 1.		0a. Method of Disposition			2	Ob. Place of	Dispo	sition (Nam	e of ce	metery,		Date				r Town, State
of He	1	1 X Burial 2 Crema	tion 3	Removal fro	om State	Restha	y or o l ve 1	ther place) n Mem	. Ga	arden	s 5/	/8/07		Frede	cick	, Maryland
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salti smit. eparte nport ijury	- 1	21. Signature of Funeral Ser	- A I	. 4112	m)	1 2	41.01	ひぇねん	~~ KA	חפי	- Dama	ISCH	Funera is, Mai	. ус	111d <u>20072</u>
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Records, P.O. Box 68760, The law requires that the death certificate be executed teath each or a special and page 2 should be detached for use as the burial - transit		LINGENDED		AMENDED												
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760, ficate b g physic s the bu		IF FEMALE: 23b. Was decedent pregnan	t in the	1 Live	birth	2		Fetal death	3	Ecto	pic pregr	nancy		Month		Day Year
leath certific e attending for use as the	cia	past 12 months?		4 Preg	nant at time	of death 5		Other (Spe	ecify)							
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Division of Vital Records, tal or Attending Physician: The law requir as after death. al Director: After this certificate has been selled in by the funeral director, page 2 should I led in by the funeral director, page 2 should I	၂ ပ	25. Was case referred to m	edical						26.Pla			ck only one)				
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ivisior or Attend after death Director:	cati	2 Accident	Investigati	28e. Pl	ace of Injur	y - At home,	arm,	street, facto	ry, offic	e building	, etc.	28f. Loc	ation (Street and No State)	umber o	or Rural Route Number,
Divisior pital or Attendours after deatheral Director: filled in by the	复	3 Suicide 6	Could not determine	d (Speci	fy)											
·		4 Homicide	ring Physic			nowledge, de	eath o	occurred at t	the time	, date and	place, a	and due to t	he caus	se(s) and ma	nner as	stated.
Division of Vital Prothe Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	l la	(Check only one) 2 Medic	al Examine	r:On the bas	is of examir	nation and/or	inves	stigation, in	my opir	nion, death	occurre	ed at the tim	e, date			
To ct To comp	Medical	29b. Signature and title of		and manne	er stated.			1	29c. Lic	ense num	ber			290. Date	signed	(Month, Day, Year)
	≥		-						Ο.	C.M.E.				May 5,	2007	
. 0	1	alless				oth (Item 220	<u> </u>									
2 1 7	1	30. Name and address of	person who	completed on the completed of the completed of the complete of	ause of dea	ner 111	, Per	nn Street	t, Balt	imore, N	MD 21	201				
10	1		m > > 1 > 1 d	THE PROPERTY OF												
10		Ana Rubio MD. 31. Date filed (Month, Da)				Signature										

			1 - For State Registrar	State of M	larylan	id / Depa		t of H	ealth a		P	eg. No.		102	00
	Physici	an	1. Decedent's Name (First, Middle, Las)							2. Date of Dea Month	th Day	Year	3. Time of D	eath
	/Medic		Virgil		Waym	an		ones			May 5,	2007		1328 E	Р М
)	Examir	er	4a. Facility Name (If not institution, give)				Location o	f Death		4c. C	County of Dea		
			WMHS-Memorial Ca		ne (in vrs	last birthday)		lberl	and If Under 2	24 Hrs.	8 Date of Birth		Allega		Foreign
	Funeral Director			7M 2∏ F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 06/09/			thplace (State or F ountry) st Virgin	
	יס		Usual Residence of Decedent								00/09/	323	Mes	O VII KII	II.a
	urylar show		10a. State 10b. County		10c. Cit	ty, Town or Lo		-						10d. Inside City	
	8a-1	Director	WV Mineral				Ridge							1XTYes 2	
	with t		10e. Street and Number Route 1 Box 1	'E CC			10f. Zip	6753	1			0g. Citiz	en of What C	ountry?	
	eath	Funerai	11. Marital Status	12. Was Decedent	Ever in U	S. 13.1				in? (Spe	acify Yes or No-	1.	USA 4. Race - Ame	erican Indian.	
	fter d	F	1 Never Married 2 Married	Amed Forces' 1 X Yes 2 □	? .	12-				Puerto	ecify Yes or No- Rican, etc.)		Black, Whi		
3	rel', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	· .		1 🗆 Yes	2∭ No	Specify:			3	Specify:	White	
21215-0036	filed within 72 hours after death with the Maryland Hyglene. other than "naturel", or items 23a or 28e-f show ent, the Medical Examinar court be notified at	Completed	15. Decedent's Ed (Specify only highest grad	cation le completed)		16a. Deced	kind of wo	rk done d	luring most	of worki	ng	16b. Kin	d of Business	/Industry	
2	within	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT us								
2	filed v Hygle ther t		17. Father's Name (First, Middle, Last)			L	ivesi	LOCK	Inspe		(First, Middle,		U.S.D.	Α.	
ä	d be ental	To Be	Oscar	Otis		Jon	nes		Anr		Gla			nons	
Maryland	shoul nd M mari	-	19a. Informant's Name/Relationship (T	vpe, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	I Route Numbe		Town, State,	Zip Code)	
	and 2 alth a 27 ls		Kathie Jones / d	aughter		Rout	e 1 E	30x 1	75CC	, Rio	dgeley,	WV	26753		
Baltimore,	of He of Ham		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Comount from State	20b. F	Place of Dispo	sition (Nar	ne of ther place	9)	D	ate	20c. Loc	ation - City or	Town, State	
Ĕ	Pag ment ent: I ury o		4 Donation 5 Other (Specify		Man						/2007				
3a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: if Itam 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examitive cust be notified at anone.		21. Signature Funeral Service Licens	98								-		Home, P	.A.
	20 E # 0		23a. Part 1. Enter the disease, or comp	alle	en-le						, Cumbe		ia, MD	21502 Approximate	
760,	Physician / Medical Examiner prize p	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a conseq	uence of): uence of):	<u> </u>	9760	hi 2 v	c scul	ler c	dis	e-se	8 ye	61
O. Box 68	it the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pr Other (sp					23	3d. Date of de Month	livery Day Ye.	ar
ο, J	igned be deta	by P	Part II. Other significant conditions co	ntributing to death t	out not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	o the cause of dea	ath?
ğ	w require been sly should b										1 🗆 Y	es 2 🗌	No 3∏P	robably 4 ZUni	known
Vital Records,	The lar ate has page 2	Completed									24a. Was a autops perfor	v	prior to death?	utopsy findings av completion of cau 2 No	railable ise of
Ĭ	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Cthe			(Check only or				-
Ö	sing After fune	ition; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju	ury	28b. Time of Injury		8c. Injury Work		2	ne 5 ☐ Reside 28d. Describe h			ocify)	
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, factory	, office		2	28f. Location (S. City or Town	reet and n, State)	Number or R	ural Route Numbe	эг,
	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in I	Medical	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	sician: To the best ner: On the basis of and manner st	of my kno of examina tated.	wledge, death tion and/or inv	occurred vestigation	at the tim in my op	e, date and inion, deat	d place, a	and due to the c ed at the time, d	ause(s) a ate and p	and manner as place, and due	s stated. e to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifler					. License			2		signed (Mont		
7	4/1UA		/ // hn	7				D367	00			M	ay 7,	2007	
	nes		30. Name and address of person who cover Vik Poonai, M.			n 23a) (Type, n Drive		mber.	land,	MD	21502				
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 200	32 Regist	rar's Signa										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Day **Physician** 2007 May 1:05 A M Louise Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** Harrow Lane Cumberland Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Dec 21, 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1□M 2/7 (Country) 212-38-6387 68 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 √Yes 2 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 1915 Harrow Lane USA Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Supervisor Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Pope Joseph Roger Pope Louise ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) / husband 1915 Harrow Lane, Cumberland, MD 21502 Roger W. Jones 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory: 5/15/07 Cumberland, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on , ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wante /Medical Te to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed physician and sthe burial-tran-Due to (or as a consequence of): attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I/2 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has e 2 autopsy page 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Inpatient မ this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide

Box 68760. Division or Vital Records, P.O. or Attending Physician; To the Hospital

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier D0054411 May 14 , 2007

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person,

M.D. 500 Memorial Ave., Cumberland, MD 21502 Beverly Calkins, 31. Date filed (Month, Day, Year)

State Registrar

12

nds

State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#7perFH5/4/07,BMW,MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2007 MAY 2:01 A JOHNATHAN ERNEST KIRK 1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 7. Age (In yrs. last hirthday). 5. Social Security Number **Funeral** 1 XM 2 ☐ F Director 238-51-7865 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow the Medical Examiner must be notified at 1 No 2 No Director NC BEAUFORT BELHAVEN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 613 CHAMBERS POINT RD. U.S.A. 27810 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Itema 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2006-1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced WHITE "natural" 2007 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. MARINE DEFENSE 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 ie marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) JOHN W. KTRK GLENDA G. LANGDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 CHAMBERS POINT RD., BELHAVEN, NC. 27810 GLENDA G. HOPKINS/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) RIDER HILLS CEMETERY 5-6-2007 BELHAVEN, NC. 21. Signature of Funeral Service Ligensee 22. Nama and Address of Facility RAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BLAST INJURIES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and ched for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 □ No 1 √Yes 2 No Division of Vital or Attanding Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 X Yes 2 □ No DURING MILITARY OPERATIONS APR 23 2007 6:40 PM 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 X Homicide To the Hospital or within 24 hours aft To the Funeral Di BATTLEFIELD FALLUJAH 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 May 07 MS 0101054497 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY USAF LtCol MC ELIZABETH A. ROUSE ROCKVILLE MD 20852 31. Date filed (Month, Day, Year) Registrar's Signature State 0 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ralph KAYE /Medical May 2, 2007 2:50 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. Aug. 400 + 18 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 400 | 5. Social Security Number 9. Birthplace (State or Foreign New York 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 88 579-44-0642 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ▼ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 N. Leisure World Blvd., #521 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M ‰es 2 □ No If ⋘s, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Š Specify: 3. ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Give kind of work done during most of working life. DO NOT use retired) Department of College (1-4or 5+) Elementary/Secondary (0-12) Agriculture Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mollie Meinster Kartzovník Aaron ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Kaye, Son 1515 Ainsley Road, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lebanon Cemetery 05/04/07 Mt. Adelphi, MD 21. Signature of Fureral Society Licens Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed Mitral Regurgitation attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) the 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Renal Failure cate has page 2 s autopsy performed? this certificate 1∐ Yes 2 😾 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

12+

29b. Signature and title of certifier

Τ.

Kariya,

04

Day, Year)

Steven

31. Date filed (Month.

DHMH 17 Rev 1/2001

State

Registrar

10605 Concord St.,

egistrar's Signature

29c. License number

D 36252

#500, Kensington,

29d. Date signed (Month, Day, Year)

May 2, 2007

and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

M.D.,

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at ance.

Baltimore, Maryland 21215-0036

physician and s the burial-transit cate has been significant of the country of the case o

Examine Physician/Medical þ Completed Be ျှ Certification: after death.

I Director: After function of the function of th

Hospital

or Attending Physician:

Division or Vital Records, P.O. Box 68760

within 24 hours af

To the Funeral D

completely filled in Medical 29b. Signature and title of certified 31. Date filed (Month, Day, Year) State

(Check only one)

D0061083

29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PAUL THAMBI, 9707 MEDICAL CENTER DR, SUITE 300, ROCKVILLE, MARYLAND

MAY 04 2007



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 11, **Physician** 2007 Vada Izora Lester /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland 12316 Williams Rd 8. Date of Birth
Feb 8, 1911 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min. 1 □ M 2 🖵 F 96 218-16-4343 Director PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. anst: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Cumberland MD Allegany 1 ☐ Yes 2 ÎNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA Williams Rd SE 12316 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) retail clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Guy O'Neal Viola Catherine (Elliott) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Flintstone Creek Rd, Clearville, PA 15535 Ines E. Kimble / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of It
Important: If Ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) Hillcrest Burial Park 5/14/07 Cumberland, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 1 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause pproximate Iterval Between Inset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or se a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has b irector, page 2 s autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 27 1 Tes P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 A Residence 6 □Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my applications in the cause of the 29a. Certifier

Mrs State

Registrar

2

Gary L. Wagoner, M.D. 31. Date filed (Month, Day, Year) 4

2007

30. Name and address of person

29b. Signature and title of certifie

(Check only one)

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

925 Bishop Walsh Dr., Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 APRIL 30, **Physician** 2:55PM M LARS MILO LARSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TALBOT EASTON TALBOT HOSPICE HOUSE If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 XM 2 ☐ F Days NEBRASKA MAY 4, 81 Director 507-18-7189 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. rther than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M. dt.al Examiner must be notified at once. 1 Yes 2 No Director EASTON MD TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IISA 1 ALBION COURT 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? X□ Yes 2□ No if Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PRIVATE DEFENSE Elementary/Secondary (0-12) College (1-4or 5+) SENIOR CONTRACT ADMINISTRATOR INDUSTRY 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be HETTIE WHELDON RAYMOMD JENNINGS LARSON ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DONNA K. SHERMAN/STEP-DAUGHTER 14410 TURBRIDGE COURT, BURTONSVILLE, MD 20866 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION, INC 5/2/2007 BELTSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 200 S. HARRISON ST., EASTON, FUNERAL HOME PA MD 21601 Ostizowski the C.F.S.A JOSEPH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cowcetis ancrea tic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence WXOther (Specify) HUSPICE 20 No 1 Tyes Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Taccident after death 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20+VA

LARSON

JEFFREY T. DENTON M.D. 555 CYNWOOD DRIVE, EASTON, MD 21601 31. Date filed (Month, Day, Year)

30. Name and address * person who completed cause of death (Item 23a) (Type, Print)

MAY 0 1 2007

29b. Signature and title of certifie

32. Registrar's Signature Seem & go

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 31) 2007 ELIZABETH LEVERANCE Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS COMMUNITY HOSPITAL PRINCE GEORGES LANHAM If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2**X** F 79 Director 239-34-0884 MAY 20, 1927 NORTH CAROLINA Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD. PRINCE GEORGES COLLEGE PARK 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9708 NARRAGANSETT PARKWAY 20740 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERBERT Τ. McMANUS ELEBERE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT LEVERANCE/HUSBAND 9708 NARRAGANSETT PARKWAY, COLLEGE PARK, MD. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 5-2-2007 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 2073 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) collapse **Physician** candio respiratory Hours /Medical Due to (or as a consequence of): Examiner Respuatory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed wm Phoma burial-tran and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. δ 2 No 3 Probably 4 Unknown 1 TYes page 2 should Completed no vas arlan 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Dath 28a. D te of injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attendl 24 hours after death. Funeral Director: 2 ☐ Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007

Registrar

State

Greenbelt, MI.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Redistrar's Signature

31. Date filed (Month, Day, Year) MAY 0 4 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 30°, 2007° **Physician** Mary K. Lemberos 5:00p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Nursing Timonium If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Days 003-24-4880 83 7/19/1923 Director Greece Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d, Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M. doal Examiner must be notified at Silver Spring MD Montgomery 1 TYes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 15100 Interlachen Drive #420 20906 USA Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 XWidowed 4 Divorced and Mental Hygiene. . Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elias Kramboviti Stavroula Lianouris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai once. Jennie Janssen/Daughter 2665 Ebony Road Baltimore, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 □ Removal from State 5/03/2007 5 ☐ Other (Specify) Fort Lincoln Brentwood, Md. 4 Donation 21. Signature Funeral Service Lice PHILIPADS RINALDI FUNERAL SERVICE.P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for each ronnaquence off Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 🖫 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the functional director, page 2 should be detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No 1⊟ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month. State 2007 04 Registrar

DHMH 17 Rev 1/2001

MARY LEMBEROS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Henry G Meinschein 1:2/PM 2007 mai /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birth Baltimore If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 86 Yrs. 8. Date of Birth (Month, Day, July 7, 9. Birthplace (State or Foreign **Funeral** Year) 20 1**X**XM 2□ F Months 215-16-6597 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other thatmatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Frederick Frederick 1 ☐ Yes 2 No Maryland Director 10g. Citizen of What Country? 10e Street and Number 6508 Spring Water Court, Unit 3203 10f. Zip Code 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Agmed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mass Transit Bus Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Mills Albert Karl Meinschein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6508 Spring Water Ct., Unit 3203, Frederick, 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary L. Meinschein, wife Department of Health ar Important: If Item 27 Is any Injury or other trac 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Resthaven Memorial Cardens May 15, 2007 ¥☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²²Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 Ruchande MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Physician /Medical Due to (or as a consequence of): Examiner Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed Congestive Due to (as a consequence of) physician a the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has b page 2 s autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient To the rusping.

Within 24 hours after death.

To the Funeral Director: After this of the funeral directory. 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P2/149 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 22 South Greene Street Baltimure, MD 21201

Registrar

State

(Month, Day, Year) MAY 1 8 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 200^{Yea} **Physician** Thomas Edward Mercer Мау 4:50pm^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 0 c t . 19, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X** M 2□ F 49 ,1957 Massachusetts 213-76-1933 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1X Yes 2 No Directo Md. Prince Georges Upper <u>Marlboro</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with USA 5408 Dower House Road 20772-3602 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14☐Yes 2☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4X Divorced Year or Dates: the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Concrete Estimator Private Industry permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event ** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wallace Mercer Edna Reeves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5401 Ancestry Ct., Gainesville, Va., 20155 Thomas Mercer Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park 5/5/07 Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bluford Funeral Service U 2670 Crain Highway, Waldorf, Md 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anox. **Physician** Encephalopath unknowy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1⊟ Yes Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 X Yes 2 No 1 🛛 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it Certification: 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar

31. Date filed (Month, Day, NAY 0 7 200

FARAHIFAR 32. Registrar's Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Georgia Avaduit 3-41 Silver spring 120

		1 - For State Registrar	State of Mary		artment of F		Re	g. No.	7 1627
Physici /Media		1. Decedent's Name (First, Midd DAVID E.	MACLIN				2. Date of Death Month May	3 2	3. Time of Death 2007 10:50A
Examir		4a. Facility Name (If not instituted Fort Washingt	ton Hospital	_		ashingt	on	4c. County	of Death e George's
Funeral Director		5. Social Security Number 391–48–8433 Usual Residence of Decedent	6. Sex 7. Age (In	n yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		1949	9. Birthplace (State or Foreig Country) Tennessee
Maryland a-f ehow	tor	10a. State 10b. Count	nce George's	oc. City, Town or Lo	vashingto	n			10d. Inside City Limit
with the	Direc	10e. Street and Number 8304 Founders	Torrago		10f. Zip Code	744	10	g. Citizen of V	Vhat Country?
be filed within 72 hours after death with the Maryland ital Hyglene. d other then "neturel", or iteme 23e or 28e-f show event, the Medical Examiner risual be inclified at	by Funeral Directo	11. Marital Status 1 Never Married 2X Ma 3 Widowed 4 Divorce	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No	1966_		<u> </u>	(Specify Yes or No- erto Rican, etc.)	14. Race	e - American Indian, sk, White, etc. African
d within 72 ho piene. Ir then "natur the Medical.	Completed		ont's Education est grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Estate Br	during most of w d)	vorking		ivate
2 should be filed and Mental Hygical III marked other raumatic event.	To Be C	17. Father's Name (First, Middle David L.	Maclin			18. Mother's N	ame (First, Middle, M	Macli	
nd 2 sho lith and 27 le ma r trauma		19a. Informant's Name/Relation Juanita E. Ma			-		Rural Route Number, Fort Was		
permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic e 2008.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 □Removal from State	20b. Place of Dispo cemetery, crer MD Veteral	natory or other place				City or Town, State
permit. Departm Importa		21. Signature of Funeral Service		22	2. Name and Addre	ss of Facility J		ral Se	rvice, Inc.
Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that caused the st only one cause on each line. a	renom		/ /	sac or respiratory arrei		Approximate Interval Between Onset and Dorn
death certificate be executed entending physician and of for use as the burial-transit	Ical Examiner	Secusinistly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co						
death certific e ettending p d for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	∃Fetal death 3□	Ectopic pregnancy Other (specify)	,		23d. Date Mor	e of delivery nth Day Year
quires that n signed b uld be deta	þ	Part II. Other significant condit	ions contributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.			ribute to the cause of death?
ysician: The law requir is certificete hes been si director, page 2 should	Completed							ed? c	Were autopsy findings availat prior to completion of cause of death? Yes 2 No
ding Ph n. After th funeral	tlon: To Be	25. Was case referred to medic examiner? 1 Yes 2500 27. Manner of Death Natural 5 Pend	Hospital: 1 Inpatient 28a. Date of Injury	2€P/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing	Home 5 Resider 28d. Describe how	nce 6 Othe	
	Certification:	3 Suicide 6 Could	*	- At home, farm, str Specify)			28f. Location (Stree City or Town,		er or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical (29a. Certifier Certify (Check only one)	ing Physician: To the best of m il Examiner: On the basis of ex- and manner stated	amination and/or in	n occurred at the tirvestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the car curred at the time, da	use(s) and ma te and place, a	nner as stated. and due to the cause(s)
To the H within 24 To the F	Me	29b. Signature and title of certific	er er		29e. Licens	e number 1943/	29	d. Date signed	(Month, Day, Year)
(9) 1Va		30. Name and address of person	n who completed cause of death	h (Item 23a) (Type.	Print)	14103	77. W.	gohrg	DJ 19200
Sta Registi		MAY 0 7 2007	32. Registrar's	Signature				· ·	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 April 25, **Physician** Robert Frank Musante 7:15 AΜ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3629 Majestic Lane Prince Georges Bowie If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F 66 142-32-4928 Director 07/06/1940 New Jersey Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County woys 10d. Inside City Limits r 28a-f show notified at Director 1√ Yes 2 No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or dical Examiner must be r 3629 Majestic Lane 20715 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: 157-161 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Mexiconce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Officer Wells Fargo Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Joseph Musante Iris Ida Iler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hope M. Scimoneilí/ Sister-in-Law 1504 Pageant Court, Bowie, Md 20716 20b. Place of Disposition (Name of cematery, cramatory or other place)
Maryland 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 4/30/07 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or pach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner or Janying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page perform certificate 1∐ Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26492 K. Dakheelm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Rivel Dakheel, m. D. 4000 Mitchellvill & Rd. Bowie, MD 207/6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 Day **Physician** 2007 Louise Minke May 5:00 P M Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 15900 Williams Road Allegany Cumberland 8. Date of Birth (Month, Day, Year) March 28,1928 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) Funeral Months Days Hours 1 □ M 2 🕁 F 79 216-22-7266 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f sh dical Examiner must be notified 1 ☐XYes 2 ☐ No Director Cumberland MD Allegany 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. Liberty Street Apt 509 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ne If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 21 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) telecommunications telephone operator injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot Thomas Edward Danahy Hazel Blanche (Sweitzer) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Thomas J. Minke / husband 10 N. Liberty St Apt 509 Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cumberland Crematory May 14, 2007 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2XXNo Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 YUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate has ral director, page 2 perform 2 🗗 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Living Hospital: 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 □ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , 2007 D0054411 May 14 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) Beverly Calkins, M.D. 500 Memorial Avenue, Cumberland, MD 21502

nas State Registrar

31. Date filed (Month, Day, Year)

4

32 Registrar's Signature

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAY 2ND 2007 ear James Alan Mettv 14:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY MEMORIAL HOSPITAL CUMBERLAND Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours 1)XIM 2□ F 216-22-7363 76 Yrs 08/28/1930 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "matural", or items 23a or 28a-f show any Injury or other traumatte axes the axes. 10c. City, Town or Location 10d. Inside City Limits Mineral Ridgelev 1 ☐ Yes 2 📉 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 26753 128 Spruce Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify þ 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Freight 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Metty, Sr. Edna Sable Earl Monroe မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Spruce Lane, Ridgeley, WV 26753 Betty E. Metty / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory | 05/04/2007 4 □ Donation 5 □ Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21502 404 Decatur Street, Cumberland, MD Ulles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): 8 Days disease or condition resulting in death) /Medical neumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 Tes 2 No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 4/IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MD. 21502 900 Seton Drive nN 31. Date filed (Month, Day, Year, Registrar's Signature State MAY 0 4 2007 Registrar

			For State Registrar	State of M	aryland /		rtmen tificat			nd Me		iene	007	162	75
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	Examir	er	4a. Facility Name (If not institution	, give street and number)					Location of	Death		4c. C	ounty of Death		
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	τ		Usual Residence of Decedent								JL1 17		72 1110		
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	death	Funeral Director	11. Marital Status	12. Was Decedent		13. V	Vas Deced	dent of Hi	spanic Orig	in? (Speci	fy Yes or No-		. Race - Amer		
9	after or its	/Fu	1 ☐ Never Married 2 💥 Marri	Armed Forces? ied 1 Tyes 2 X If Yes, Give	No		Yes :		n, Mexican, Specify:	Puerto Hi	can, etc.)		Black, White	, etc.	
21215-0036	within 72 hours after death with the Maryland ane. then "naturet", or iteme 23e or 28e-f ehow he Medical Exeminer must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:									V	HITE	
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b	at Hyg	Bec	17. Father's Name (First, Middle,						18. Mother	's Name (First, Middle, N		W.F		
yla	Ment Ment arked	To	ELMER J. RII	DENOUR					DOI	RCAS	ZIRK				
Maryland	12 sh and r is m raum		19a. Informant's Name/Relations		(_				Route Number,	•		p Code)	
	1 and Health		GAIL METHENY / 20a. Method of Disposition	HUSBAND	20b. Place				RK RO	AD, M	OOREFII		WV 26 ation - City or 1	0836_ Town, State	
ğ	ages int of t: ff it y or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		сете	etery, crem	natory or o	ther place	1						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene Important: if item 27 is marked other then "naturel", or iteme 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at ance.		21. Signature of Funeral Service	-) OL	22		d Addres	s of Facility		/2007 _		OREFIE	LD, WV	
m	Dem Timpo		Trance 9.	Lachene	L		GIFF	IN FU BOX	UNERAI	L HOM	E, INC. N BRID	Er t	WV 267	11	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. D	Do not ente	or the mod	e of dying	g, such as c	ardiac or i	espiratory arre	st,	20,7	Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	a. Anoxic	encepl	halor	athy							Onset and D	
	/Medical Examiner		resulting in death)		a consequence		GOIL							24 110	urs
٠	ZAGIIIIICI	76	Sequentially list conditions, if any, leading to immediate	b. Ventri	cular		11at:	ion_						24 no	urs
	uted I Insit	Examiner	Cause (Disease or injury	200.10 (0.120	a consequent	50 01).									
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89 x	res that the death certifica igned by the ettending ph be detached for use as th	Physician/Med	IF FEMALE:							<u> </u>		<u> </u>			
Вох	ettend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal dea	ath 3 🗌	Ectopic pr					23	d. Date of delive Month		/ear
o.	y the character of the	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	time of death	3	Other (sp	ecily)							
s, P	The law requires that the sie has been signed by the bage 2 should be detache	by Pr	Part II. Other significant condition	ns contributing to death b	ut not resultin	g in the un	derlying c	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of d	eath?
rds	w require been sig should b										1 ☐ Ye	s 2	No 3□ Pro	bably 4 □U	Inknown
Vital Record	law requ es been 2 shoulk	Completed									24a. Was ar autopsy		24b. Were aut	opsy findings a	
<u> </u>		Com									perform	No No	death? 1 ☐ Yes	_	2030 01
Vita	Physicien: The lav this certificete hes rai director, page 2	Be	25. Was case referred to medical examiner?	Hamital: V				104		of Death (Check only one)			100
ō	Phyer this rai dir	٦.	1 ☐ Yes 2 2 No 27. Manper of Death	Hospital: Inpatie		Outpatient	-	8c. Injury	4 🗆 (40):		5 Reside			fy)	
o	Attending Phyrdeath. cotor: After thi by the funeral	tion	1 Natural 5 Pending 2 Accident investig	(Month, Da	y Year)	Injury	M 2	Work	al ? ∕es 2 □ N		d. Describe ho	w injury (occurred		
Division	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ot be 28e. Place of Inj	ury - At home,	, farm, stre	et, factory	, office		28	Location (Str		Number or Rui	al Route Numi	ber,
Ó	s afte oi Dir od in	Certification;		building, et							City or Town				
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical I	g Physician: To the best Examiner: On the basis o	r examination	dge, death and/or inv	occurred estigation	at the tim	e, date and inion, death	place, and	d due to the ca	use(s) ai	nd manner as	stated. to the cause(s))
	To the h within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner sta	ated.			License					signed (Month		
	, ž ž Š		> /INION:	· Van	m,	MI		D254			23		lay 4,		
7	,		30. Name and address of person									1.1			
	nes		William Lamm,M					UMBE	RLAND	, MD	21502				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	A	make :	5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Registrar MD, TCHD, 05/14/2007 pha
Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 52 A ODVE tori 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Man Ad Bul Midical Mure If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Year **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ XF Months Director 217-82-0516 12-03-1964 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 ☐ No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 29345 Fourth Street Funeral 21601 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify. Completed by Specify: 3 Widowed 4 Divorced "natural", Year or Dates Black. other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GNA/CMA The Pines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Mental I မ Thomas Edward Hutchins Delores Blackston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Hutchins / Mother 29345fourth Street, Easton, Maryland 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olive Cemetery 04-21-2007 Butlertown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 SILLILLIS. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Respiratory Distress Syndrome Immediate Cause (Final **Physician** 8 days disease or condition resulting in death) Kervin win /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) P.0. cate has been signed by the page 2 should be detached The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✓ nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 No 1 ☐ Yes ပ 2 ER/Outpatient 3 DOA 27. Manner of Deat Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2007

			For State Registrar	State of Ma	ii y iai i		ertifica			ivicinai i		No.O O	'y my	10077
15-			1. Decedent's Name (First, Middle, Las	st)						2. Date of	Death	201	11	3. Time of Death
	Physicia		Jelena Iva	novic	M	lcCle1	lan			Month April	27.		Year	10:30 a ^M
	/Medic Examin	_	4a. Facility Name (If not institution, give	e street and number)				, Town, or	Location of Deat		Ť	4c. County o	f Death	
	Examili					7.4						34 -		
-	Funeral		19574 Crystal Ro 5. Social Security Number 6. S	ck Drive, ex 7.Age	Apt (In yrs. I	last birthda	y) If Unde	ermai r 1 Year	f Under 24 Hrs	8. Date of	Birth	Mon	9. Birthp	lery lace (State or Foreign
	Director		102-38-0628	□M 2SxF	6	9 Yrs.	Months	Days	Hours Min.	May	Day, Ye		Cour Yuac	oslavia
			Usual Residence of Decedent						· · · · · · · · · · · · · · · · · · ·	Tidy	·, ·	551	Luge	Biavia
	yland jow		10a. State 10b. County		10c. City	y, Town or	Location						1	0d. Inside City Limits
	Mar-f sh	p	Maryland Montgo	merv	G	erman	t own							1 □Yes 2 No
	the noti	9	10e. Street and Number	mory ,		<u> </u>		p Code			10g.	Citizen of Wh	nat Cour	ntry?
	with sa on		19574 Crystal R	ock Drive.	Ant	. 14		20	0874			USA		
	ns 2 mus	Funeral Director	11. Marital Status	12. Was Decedent B			3. Was Dec		ispanic Origin? (S an, Mexican, Puer	Specify Yes or	No-	14. Race	- Americ	an Indian,
	fter c	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 N	lo					to Hican, etc.,	}		, White,	
-0003	al", o	by	3 ☐ Widowed 4XD Divorced	If Yes, Give Year or Dates:			1 ∐ Yes	2 K No	Specify:			Specify	hite	:
ş	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show thet the Medical Examiner must be notified at	Completed	15. Decedent's Ed	Jucation		16a. De	cedent's Us	ual Occup	ation	-t-i	16	o. Kind of Bus	iness/In	dustry
<u></u>	nin 7; n "n Medi	be	(Specify only highest gra	College (1-4or 5	+)	life	e. DO NOT	use retired	during most of wo f)	rking				
7	yiene r tha the l	E	12	conege (1 401 c	.,		Bank	Telle	er			Banki	ng	
9	othe ent,	BeC	17. Father's Name (First, Middle, Last)						18. Mother's Na	me (First, Mic	idle, Mai	den Surname)	
yrand	ld be enta ked c ev	To B	Ljuborad Ivanov	ic					Katar	ina Unl	know	n		
	shound M M md M mar	-	19a. Informant's Name/Relationship (Type. Print)		19b. Ma	iling Addres	s (Street	and Number or R	ural Route Nu	ımber, C	ity or Town, S	tate, Zip	Code)
Z Z	nd 2 and 11th an 11th an 27 is 27 is 1 trau		Charles Elliott	McClellan/	Son	2	253 M	yrtle	e Point	Way, H	ende	rson,	NV 8	9052
a)	Hea Hea tern	ŀ	20a. Method of Disposition				position (Na		100	Date	200	c. Location - C	City or To	own, State
2	nt of		1 ☐ Burial 2 ★ Cremation 3 ☐		°	emetery, c	rematory or	orner prac	Ma;	у 3,				
	rtand njun	-	4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		_Met	ropo 1	itan	Crema	story ss of Facility	2007	A1	exandr	ia,	Virginia -
Daltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		2. Ken Sicile	isee			Franc	is J	. Collin					
				alications that assessed	the death	Do not	500 U	nive:	csity Bl	vd, W.	, Si	lver S	prin	g, MD 2090:
	9,112,3		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	ie.	i. Do not e	sinter the inc	ide of dyli	ig, socii as cardia	o or respirato	ry arrest	,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Atherosc	lero	tic C	orona	ry A	rtery Di	sease				
	/Medical Examiner		resulting in death)	Due to (or as a				-	-					
	Examine		Sequentially list conditions.	bSystemic Due to (or as a	Нуре	rtens	ion_		-					
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Ď,	e exe ian a irial-	Ä	resulting in death) cast	Due to (or as a	a consequ	uence of):								
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ŏ	ntifica ng ph as t		IC CENALE.									T		
o o	th cell endir	Physician/N	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			3 □Ectopic	oreanancy	/			23d. Date		
0	deal e att	ici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			5 ☐ Other (_	Mon	ın	Day Year
5	t the by th	hys	9 ☐ Unknown	9EJOHKHOWH										
, Ç	s tha	by P	Part II. Other significant conditions of					cause giv	en in Part I.	23e. E	oid tobac	co use contrib	oute to t	he cause of death?
Hecords	w requires that the death cer been signed by the attendin should be detached for use		Coronary Artery	Stenting,	Nove	mber	2006			1	☐ Yes	2 → No 3	3 Prob	oably 4 □Unknown
္ဌ	law rer as bee 2 shor	Completed	Bronchitis, Janu	ary 2007							Vas an	24b. W	ere auto	ppsy findings available
T T	The law ate has bage 2 s		DIGHTELDY CUMA	ary zoor						р	utopsy erforme	d? de	eath?	mpletion of cause of
VITAI	n: T ficate or, pa		25. Was case referred to medical						26. Place of De		es 2X	INO II	Yes	2□No
5	Physician: The la r this certificate has ral director, page 2	Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2□	EB/Outpat	iont 3 🗆 E	Oth	or.	,		e C Dother	- (C-cci	5.d
5	Phy rthis ral di	<u>1</u>	27. Manner of Death	28a. Date of Injur		28b. Time		- CA	4 LI Nursing I	1		injury occurre		у)
	Jing Afte fune	io	1X Natural 5 ☐ Pending	(Month, Day	Year)	Injur	y M	28c. Injur Wor	k? Yes 2∐No					
<u>s</u>	ttend death stor: the	icat	3 Suicide 6 Could not be	e 280 Place of init	ırv - At ho	ome, farm.				28f Locatio	on (Stree	et and Numbe	r or Rura	al Route Number,
DIVISION	after a Direc	Certification:	4 ☐ Homicide determined	building, etc	. (Specif	y)		.,,		City or	Town, S	State)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
-	spital or Attending Phours after death. Ieral Director: After the filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best o	of my kno	wledge de	ath occurre	d at the ti	me date and place	e and due to	the caus	se(s) and man	ner as s	tated
	Hos 24 ho Fun stely	Medical		miner: On the basis of and manner sta	examina									
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	- ^	1		2	9c. Licens	e number		29d	. Date signed	(Month,	Day, Year)
	F 3 F 8		(O () ()	1 8 miles	4_			50	0653		0	5-0	12.	-07
4	50		30. Name and address of person who	completed estimated	aath /lta-	23a\ /Tv-	a Print\		0					-
	(Daniel Fernicola					a Po-	ad, #306	Rock	7111	o Mr) '	2025	0
	Sta	te	31. Date filed (Month, Day, Year)	32 egistra	ar's Signa	ture	4		1500 H	MOON	· '	-, IIU		
	Registr		31. Date filed (<i>Month, Day, Year</i>) MAY 0 4 2	197 Maga		K A	beels	9						

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Dew	ayne Edwar		chols 1- For State	State	of Maryla		artment of	f Health an	d Mental F	lygiene	200	07 16	07
	Physicia		Registrar 1. Decedent's Name	e (First, Middle,La	st) Duane F	dward Nic		Death		2. Date of Dea	teg. No. 🥕 🚺 ath	3. Time of Death	h
N	Exami		Dewayne	Edward	Nichols-	Duane N				Month April 30, 2	Day Year 2007	0230 hrs	
	1900		4a. Facility Name (i		ve street and nu	mber)		4b. City, Town, or	Location of Dear	th	4c. County of Prince G		
	_		1307 Early 6		Sev T	7. Age (In yrs. I	ast hirthday)	Lanham If Under 1 Yea	ar If Under 24Hi	rs 8 Date of B		9. Birthplace (State or	
	Funeral Director		579–76 – 1		X M 2 F	48	Yrs	Months Day				Foreign Marylan	
		H	Usual Residence of	· L	23 M 2 F		113				-		
	' any	Ī	10a. State	10b. County	<u> </u>	-	Town or Local					10d. Inside City	
	land f shov	ō	Md.		George's	<u> </u>	Lanham		0 31			1 X Yes 2	No
	Mary or 28a-	Director	10e. Street and Nu				•	10f. Zip Code	20706		10g. Citizen of What U.S.A		
	r death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status	Elmira A		edent Ever in U	.S. 13. Wa	as Decedent of Hi		Specify Yes or N		American Indian, Black	k,
	leath w	Funeral	1 X Never Marrie	ed 2 Marrie	A === = = = = = = = = = = = = = = = = =			es, specify Cuba			White		
	after call, or	by F	3 Widowed		d If Yes, Give Yea or Dates:		1	Yes 2 X No			Specify:	American	
	hours 'natur Exam	ed	15. Decedent's Ed					nt's Usual Occupa nost of working life			16b. Kind of Bus	siness/Industry	
	36 hin 72 e. than	ple	Elementary/Seco	ondary (0-12)	College (1 2 yrs	-4 Of 5+)	Act	or			Movie	9	
	5-00 ed with lygien other he Me	Completed	17. Father's Name								Maiden Surname)		-
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medi	Be		d Wright						P. Nic			
		٢	19a. Informant's Na Gloria P	me/Relationship • Nichol	(Type, Print) s Spease	e/Mothe		g Address (Stre Elmira			mber, City or Town 20706	, State, Zip Code)	
	and 2 sho fealth and item 27 is traumat		20a. Method of Dis			20b.	Place of Dispos	sition (Name of ce		Date		City or Town, State	
	Baltimore, bermit. Pages 1 at Department of Hee Important: If ite		1 X Burial 2			om State Ha	crematory or of armony	Mem. Par	k 5,	/8/07	Landove	er, Marylan	nd
	Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 21. Signature of Fu	ineral Service Lice	ensee		22.	Name and Addres	s of Facility	l Sons	Co Inc		
	E F P E				W. U.	1 oil	4	925 Burr	oughs Av	e.,N.E.	,Washing	ton, D.C. 200)19
1	ysician Medical		23a. Part I. Enter the fallure. List or	ily one cause on	each line.		n. Do not enter	the mode of dying	, such as cardiad	or respiratory a	rrest, shock, or hea	rt Approximate I Between Ons Death	interval set and
	Examiner		Immediate Cause or condition resulti		Due to for as a	consequence						Deali	
			Sequentially list co	enditions,	D								
		iner	if any, leading to in	nmediate orlying Cause	Due to (or as a	consequence	of):						
	d Sit	Examiner	(Disease or injury to events resulting in	mat initiated		consequence	of):		·		.		
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	6876 certificate nding phy se as the b	an/N	23b. Was decedent past 12 months		1 Live b	irth		etal death 3	Ectopic preg	nancy	Month	Day Ye	ear
	Box 6876(e death certificate the attending phy ed for use as the be	Physician/M	1 Yes 2	No 9 Unknov	7 4 16	ant at time of	5 0	ther (Specify)					
	O. B nat the de d by the etached		Part II. Other sign	ificant condition			resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contri	bute to the cause of dea	ath?
	F, P.C ires that signed 1 be deta	d by								_ 1 _ Y	es 2 🗸 No 3	Probably 4 Unk	known
	ords, w requir s been s should	olete					_				opsy p	Vere autopsy findings a rior to completion of cau	
	tal Recol	Completed								1 ✓ Yes		eath? ✓ Yes 2	No
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	f Vi Physi er this eral dir	ြို	1 ✓ Yes 27. Manner of Dea	2 No	28a. Date	of Injury	ER/Outpatien		ury at Work?	sing Home 5	Residence 6 ve		
	ion of tending Pheath.	Certification:	1 Natural	5 Pending	FOUND	, Day,Year)	FOUND:		Yes 2 ✔ No	Subject sh			
	Division tal or Attendin rs after death.	ifica	2 Accident 3 Suicide	Investiga 6 Could no	20a Plac		0221 hrs nome, farm, stre	et, factory, office	building, etc.	28f. Location or Town,		er or Rural Route Numb	er, City
	Division Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the	Cert	4 V Homicide	determin		Single Fa	mily			1307 Early	Daks Lane, Fairn	nount Heights, MD	
	Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only one)	Certifying Phys	ician: To the bes	st of my knowled of examination	dge, death occu and/or investiga	arred at the time,	date and place, a	nd due to the ca	use(s) and manner e and place, and d	as stated. ue to the cause(s)	
	To the within 2 To the complet	Medical	29h Signature and		and manner s	tated			se number			ed (Month, Day, Year)	
			(81	7 Lan 6	ofoil	0		0.0	.M.E.		April 30, 20	007	
CA	2		30. Name and add	ress of person wh	o completed cau	se of death (Iter	m 23a)						
-/-			Laron Lock		istant Medica			n Street, Balt	imore, MD 21	1201			
	S	tate	31. Date filed (Mor	oth, Day Year)	2. 32. R	egistrar's Signa	City						

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month М **Physician** May 2, 0720 2007 Katherine Neal Naoma /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Mandrin Hospice House Harwood If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs. March 29,1925 Washington, DC 82 Director 578-20-8001 Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 28e-f show item 27 is marked other than "natural", or items 23s or 28e-f show other traumstic evant, it a Modical Examiliar relationships or other traumstic evant, it is Modical Examiliar or other traumstic evant. 1 ☐ Yes 2 No Anne Arundel MD North Beach Director 10g. Citizen of What Country? 10e Street and Number 20714 U.S.A. 651 Alder Place Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Be Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 Is marked othar than .rry or other traumatic evant, Ite Ms College (1-4or 5+) Elementary/Secondary (0-12) trade association 12 personnel director 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jessie Viola Rhine Elmer Fersinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2002 Boyds Trail, Owings, MD 20736 Kay Meyers, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Renfoval from State permit. Page Department of Important: If any injury or Metropolitan Crematory 05-03-07 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearthalities. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 months **Physician** Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? ö 5 Other (specify) ☐Yes 2 No P.O. detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2∏ No 2X No 1 Yes certificate 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) hospice 1 ☐ Yes 2 X No 3 DOA ဂ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of in by the funeral 27 Manner of Death After Certification: or Attanding Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide after within 24 hours fo the Funaral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 2, 2007 w D 21438 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael
31. Date filed (Month, Day, Year) J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401 State Registrar

		•	For State Registrar	State	of Maryla	and / Depa <i>Cei</i>		t of He e of D		Mer		giene leg. No. (2007	16280
	Diam'r.		1. Decedent's Name (First, Middle	e, Last)	·						Date of Dea Month	ith Day	Year	3. Time of Death
	Physici: /Medic		Eva Marie NEFF								ſay 7,			23:35 ^M
	Examin		4a. Facility Name (If not institution		number)		4b. City,	Town, or L	ocation of Dea	ath			County of Death	
			9631 Garis Sho		7.4			agers	town	rc 0	(0)		ashingt	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F		rs. last birthday) 8 Yrs.	Months		Hours Mi	n. 8.	Date of Birtl (Month, Day ay 29,	, Year) 191	Cou	place (State or Foreign Intry) Cyland
	Director		220-16-2891 Usual Residence of Decedent			,0				ITI	ay 29,	191	.o Hai	yrand
land	A II		10a. State 10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits
Man	fied	to	Maryland Was	hington		Hage:	rstow	n						1 ☐ Yes 2 🔼 No
the	r 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Cou	intry?
£	23a c	aiD	9631 Garis Sh	op Road				21	.740			1	USA	
dea	E S	Funerai	11. Marital Status		ecedent Ever in Forces?	1 U.S. 13.	Was Dece	dent of His	panic Origin? , Mexican, Pue	(Specify	Yes or No-	14	4. Race - Amer Black, White	
3	함	y Fu	1 Never Married 2 Marr	ried 1 ☐ Yes	s 2 🔀 No		1 🗆 Yes		Specify:			5	Specify: wh	_
	ural.	d by	3 ☑Widowed 4 ☐ Divorced		Dates:	100 Dece	damata Hay	-1.0	·		1	16h Kin	d of Business/li	ndu atau
<u>5</u>	THE PERSON	Completed	(Specify only highe			(Give	kind of wo DO NOT i	al Occupat ork done du ise retired)	ring most of w	vorking			identia	
22.	there	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		retar						structi	
2 2	Hyg ont,	BeC	17. Father's Name (First, Middle,	Last)				1	I8. Mother's N	ame (Fi	irst, Middle,	Maiden S	Sumame)	
	ked ked	To B	Jacob Markwood	Carter					Lolli	e Es	stell	Frit	z	
Maryland 21215-0036	ama uma		19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Addres	s (Street ar	nd Number or	Rural Ro	oute Numbe	r, City or	Town, State, Zi	ip Code)
Z, 500	er tra		Russell U. Nef	f - son		9639	Gari	s Sho	p Rd.,	Hag	gersto	wn,	MD 21	740
altimore,	of He		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Demoval fro		 Place of Disposers cemetery, creation 	sition (Na matory or	me of other place,		Date			ation - City or T	
Ĕ	ant: h		4 Donation 5 Other (S		R	est Hav	en Ce	meter	y 5/1	0/07		Hage	erstown	, Maryland
<u>a</u>	Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28e-f show eny injury or other traumatic event, the Madical Examiner must be multiled at 00ce.		21. Signature of Funeral Service										AL HOME	
m s	CQ E = 8		James J.	Spices		4.	15 E.	Wils	on Blv	d.,	Hager	stow	n, Mary	land 21740
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that tonly one cause or	nt caused the de n each line.	eath. Do not en	-					rest,		Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition	a	Park	insu	m	. (des es	se	,			1469r
	Medical xaminer		resulting in death)	Due	to (or as a cons	sequence of):			des eo					
	Xaiiiiiiei		Sequentially list conditions,	b	+ai	lune	to	Ihr	ive		-			6 monus
pg	sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due 1	to (or as a cons	sequence or):								
Kecut	and I-tran	хап	that initiated events resulting in death) Last	c	to (or as a cons	sequence of):	-							
I Records, P.O. Box 68760, The law requires that the death certificate he executed	physicien and the burial-transit	a. E			•	,								
687	phys s the	edicai		d										
X	ed by the attending a	/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pre							23	3d. Date of deli-	very
Box	d for	ciar	in the past 12 months?	4□Pre	e birth 2□F egnant at time o		∃Ectopic p ∃Other (s						Month	Day Year
P.O.	by the	hys	9 Unknown	9□ Un	known							. 1		
S. Thai	been signed t should be det	Completed by Physician/Me	Part II. Dther significant conditi	ons contributing to	death but not	resulting in the u	nderlying	cause giver	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ž į	on signal	ed th								- [1 🗆 \	′es 2 🗆	No 3∏Pro	bably 4 Unknown
000	s bee	piet									24a. Was		24b. Were aut	topsy findings available ompletion of cause of
A P	ite has	E									perfo	rmed?	death? 1 ☐ Yes	Ż ∕ Ø No
ital		Bec	25. Was case referred to medica	al					26. Place of D	eath (C				
Division of Vital Records,	this ce al direc	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 (☐Inpatient 2	ER/Outpatie	nt 3 D	OA Other	4 Nursing	Home	5 🗷 Resid	ience 6	Other (Spec	afy)
0 2	fter th	ü	27. Manner of Death 1 Natural 5 □ Pendi		te of Injury lo <i>nth, Day</i> Year	28b. Time of Injury		28c. Injury Work?		28d	. Describe h	now injury	occurred	
Vision	or: A	cati	2 Accident invest	igation			М	1 🗆 Y	es 2 No					
Ž	Irect Irect	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Pla	ace of Injury - A ilding, etc. (Spe	it home, farm, st ecify)	reet, factor	ry, office		28f.	Location (S City or Tox	Street and vn. State)	Number or Ru	ral Route Number,
Div	within 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral		00 O will with a	Oh: 1.1. =							4			
H	Fune Fune tely fi	Medical	29a. Certifier X Certifyi (Check only 2 Medical	ng Physician: To Examiner: On the	e basis of exam	knowledge, deal iination and/or ir	n occurred vestigation	at the time n, in my opi	e, date and pla nion, death oc	curred a	due to the at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
Tothe	thin 2 the mple	Med	29b. Signature and title of certific		anner stated.		29	c. License	number			29d. Date	signed (Month	i, Day, Year)
1	8 7 8		· Main	91	LOST			028	365			5-	9-67	
)			30. Name and address of person	who completed =	alice of death in	Itom 23a) /Tur-	Print)	V 20	703					
LH	1-3		M AN 2 AR		APP	3 6 8 7	ull	e s	treed	· H	egsx	lemi	L MI	12/740
	Sta	ite	31. Date filed (Month, Day, Year) 32	. Registrar's Si		1 . 1	,			- 0			
	Regist		MAYO	9 2007	Edward .	D. 16	paris							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 16281 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 1, 2007 2053 hrs Medical Examiner BONG HUI PYO 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 13318 Needle Wood 23 I 8 Need I Terrace Pine Terrace
7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 5. Social Security Number Funeral oreign Months Days Hours Country)S Director 642 20 7548 M 2 XF 61 23 1945 KORE Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No MONTGOMERY or 28a-f show 23a or 28a-f show notified at once, MD SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 KOREA 這 12318 NEEDLE PINE TERRACE 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? Pages 1 and 2 should be filed within 72 hours after death Never Married Married Yes Specify: ASIAN Yes 2 X No specify: If Yes, Give Year "natural", e Widowed **X**Divorced ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ ont of Health and Mental Hygiene.
at: If item 27 is marked other than "other traumatic event, the Medical 12 HOUSEWIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) S. K. PYO В. S. KIM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12318 NEEDLE PINE TERRACE SILVER SPRING MD. MOLLY HONG. (DAUGHTER) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) NORBECK MEMORIAL 5/7/7 tunent crant: OLNEY MD Other Specify 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 21 Sinature 12303 KAYAK DR UPPER MARLBORO Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line Death a. Asphyxia Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit requires that the death certificate be executed UNPENDED X AMENDED 4a. & 28 f. PerMEOPGC5-7-07cr attending physician or use as the burial 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy

Physician (Medical aminer

timore, MD 21215-0036

the Hospital or Attending Physician; thin 24 hours after death. the Funeral Director: After this certifi npletely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760.

6	1 2	•		- 1			
I Exar	Medical Certification: To Be Completed by Physician/Medical Exar	y Phys	ompleted b	: To Be C	ertification	edical C	Σ
ransit	completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	letached for	age 2 should be d	eral director, p	lled in by the fun	completely fil	_
					within 24 hours after death.	within 24 hou	
nein	To the Hospital or Attending Physician: The law requires that the deam certificate be executed	nat the deat	ne law requires t	g Physician; 1	ital or Attending	To the Hospi	

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of de	2 Fetal death ath 5 Other (Spe		ancy	Month	Day	Year
Part II. Other significant conditions	contributing to death but not re	esulting in the underlyin	g cause given in Part I.		cco use contrib		
				24a. Was an autopsy performe	pri ed? de		ndings available ion of cause of
25. Was case referred to medical			26.Place of Death (Check	only one)			
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other Nursi	ng Home 5 Re	esidence 6 🗸	Other: Scene	9
27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND: May 1, 2007	28b. Time of Injury FOUND: 2040 hrs	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how Subject hange	ed self		
Accident Investigation Suicide 6 Could not be determined	28e Place of Injury - At hi		28f. Location (Street and Number or Rural Route Number, Ci or Town, State) 12318 Needle Pine Terr 13318 Needle Wood Terrace; Silver Spring, Md.				

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year) May 2, 2007

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

O.C.M.E.

State Registrar one)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State	State of Marylan			t of He		Mental H			10262
		54	Registrar 1. Decedent's Name (First, Middle, Last	·)	001	tincat	010	Calli	2. Date of I	Reg. No Death).	3. Time of Death
	Physicia		Gloria Pa						May 4	Da 4 . 200	y Year	11:50P M
. 4	/Medic Examin		4a. Facility Name (If not institution, give			4b. City,	Town, or I	_ocation of Dea			. County of Deal	
J. M.	- LAGITIII		Civista Medica	1 Center		Lap	lata				Charle	S
1	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	**		r 1 Year	If Under 24 Hrs Hours Min		Birth Day, Year)	9. Birt	hplace (State or Foreign
*	Director		217-42-2436	□ M 2 🟋 64	Yrs.				Jan.	24,19	943 Mar	yland
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Manyi 1 sho	ō	Maryland Charles	P	ryans	Road						1 ☐ Yes 2 🔀 No
	28a-	Directo	10e. Street and Number				Code			10g. Ci	tizen of What Co	ountry?
	3a or		6924 Skyline Place				20616				U.S.A.	
	deati	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Dece	dent of His	panic Origin? (, Mexican, Pue	Specify Yes or	No-	14. Race - Ame Black, Whit	
9	or ite		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes	•	Specify:	,		Specify: Wh	
Ö	filed within 72 hours after death with the Maryland Hygiene. the than 'natural', or itema 23a or 28a-f show ent, the Macincal Examinar must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:	160 Dane	dont's Llou	ol Ossumai	tion		165 K	(ind of Business	
7	n 72 n nat	lete	15. Decedent's Edi (Specify only highest grad	de completed)	16a. Deced (Give life.	kind of wo	ork done du ise retired)	uring most of wo	orking	100.1	and or beamers	madsky
7	with ene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	make:	r			Не	er Home	
D	Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Midd	dle, Maider	Sumame)	
/lar	uld be Venta Venta rrked	To B	Morris Dyson Welch	า				Evelyn	Mildre	ed Pet	terson	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23a or 28a-1 show any injury or other traumatic event, the Macinal Examinational Language.		19a. Informant's Name/Relationship (7)			-					or Town, State, . Md. 206	
e o	1 and 1 eaith 1 m 27		Robin Howell 20a. Method of Disposition	Daughter		-				-	ocation - City or	
Baltimore,	if its	M	1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crei	natory or	other place	May 9,	2007		·	Maryland
턡	artme artme ortant injury	1	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License					Gardens of Facility		_	.TOOLL, I	Maryrand
Ba	Dep impo		1 Marles Dul	M0066	8 8	Villi 1270	ams F Hawth	orne Ro	Home, F L. Indi	A. an He	ead, Md.	20640
			23a. Part 1. Enter the dispase, or comp shock, or heart failure. List only	lications that caused the deat	h. Do not ent	ter the mo	de of dying	, such as cardia	ac or respirator	y arrest,	•	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Embly	sem	a						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con ser	uence of):							
	LXammer	L.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	mence of)-							
	ted nsit	Examiner	Cause, Enter Underlying Cause (Disease or injury									
_,	execu n and al-tra	Xar	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
8760,	icate be executed physician and s the burial-transit	dical		d								
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Вох	th cer lendir r use	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta]Ectopic p	pregnancy				23d. Date of de Month	livery Day Year
0	e dea the att	Physician/Me	in the past 12 months? 1 □ Yes = 2 □ No 9 □ Unknown	4☐Pregnant at time of d 9☐Unknown	leath 5	Other (s	pecify)			-	NOTE	Day
<u>с</u>	es that the death certific igned by the attending b be detached for use as	F.	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	in deriving	CALISA GIVA	n in Part I	23e. D	id tobacco	use contribute t	o the cause of death?
ds,	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	d by	Tarring and angular and angular and angular an		oning in the s		3.10		1_	Yes 2	2 No 3 P	robably 4 Unknown
Ö	w requir been si should	etec							24a. W	has an	24h Were a	utopsy findings available
Vital Records,	The lav	Completed							at pe	utopsy erformed?	prior to death?	completion of cause of
<u>a</u>	ician: Th certificate rector, pag	e C	25. Was case referred to medical					26 Place of D	1 ☐ Ye eath (Check on		o 1 □ Ye	s 2□ No
>	S 0 0	ToB	examiner?	Hospital:	ER/Outpatie	nt 3 D	OA Othe				6 □Other (Spe	ecify)
J of	ding Ph h. After thi funeral		27. Manner of Death 1. ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of	28c. Injury Work				ury occurred	
Sio	Attending or death. ector: Atler by the fune	satic	2 Accident investigation			М		res 2 □ No				
Division	or Attendate after death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st fy)	reet, facto	ry, office			n (Street a Town, Stat		ural Route Number,
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	e owledge, deat	th occurre	at the tim	e, date and place	ce, and due to t	the cause(s	s) and manner a	s stated.
	e Hoe 124 h	Medical		niner: On the basis of examina and manner stated.								
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier	1.40		29	c. License		a		ate signed (Mon	
			1 Man	tath			ء (ل	5228	-/		5) 5/	7
0	n r	1	30. Name and address of person who				10	7 11 7 1	C 347		0.1	
1	CCK		Nalin Mathur 31. Date filed (Month, Day, Year)	11855 Holly] 32. Signistrar's Signi		ouit	e 10	/ Wald	ort,ML	206	100	
	Sta Regist			2007 Serve	B A	back	1					

		1 - For State Registrar	State of Maryland / D	Department of He Certificate of D		Reg.	Sum Con True of	16283
Physici /Medic		1. Decedent's Name (First, Middle, Last) Paul	F	Proctor	Sr.	2. Date of Death Month May 0	2 2007	3. Time of Death 8:31p M
Examir		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or I			4c. County of Death	
		Holy Cross Ho		Silver	_		Montgome	
Funeral Director		5. Social Security Number 6. Sex 1579 – 48 – 8596	M 2□F 88	thday) If Under 1 Year Months Days Yrs.	Hours Min.	8. Date of Birth (Month, Day, You 12/10/1		lace (State or Foreign htry) yland
Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town				1	0d. Inside City Limits 1 Yes 2 □ No
the N	Director	Maryland Prince 10e. Street and Number	George Clin	10f. Zip Code		10g	. Citizen of What Cour	ntry?
h with	0	7705 Old Alexan	dria Ferry Roa	ad 2073	35		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumette event, the Medical Examiner must be multified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto Specify:	ocity Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
hours itural;	ed by	3 Widowed 4 □ Divorced	Year or Dates:	Decedent's Usual Occupa	tion	16	Specify: Bla	
vithin 72 ne. hen "ne	Completed	(Specify onfy highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)	uring most of worki	ng	rinity C	
filed v Hygie thert	e Co	12 17. Father's Name (First, Middle, Last)	GIC	ound Superi		(First, Middle, Ma		Offege
uld be Mental Irked o	To Be	Benjamin		roctor	Elizabe			arley
2 sho and I s ma	ľ	19a. Informant's Name/Relationship (Type		. Mailing Address (Street a				
l and fealth m 27 her tr		Alethea Contee/		5101 Baden			c. Location - City or To	
in the		1 X Burial 2 ☐ Cremation 3 ☐ R	enioval iloni State	Disposition (Name of y, crematory or other place)			
artmer strant ortant injury		4 Donation 5 Other (Specify) 21. Signature of Juneral Service Conse		rection 22. Name and Address			inton, M eral Hom	
permit. Pages Department of Importent: If It any Injury or once.		Jay Jack	191	20605 Aqu				
Physician /Medical Examiner		23a. Fart1. Enter he diseas or complishock, or h-art failure. List only in Immediate Cause (Final disease or condition resulting in death)	Acute myocar Due to (or as a consequence esophageal	dial infar on: gastric c	ction	r respiratory arrest		Approximate Interval Between Onset and Death
cate be executed physicien and sthe burial-transit	dical Examiner	flany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Chronic rena Due to (or as a consequence of	l insuffic	iency			
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day Year	
requires that een signed t	5	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause give	n in Part I.		cco use contribute to t	
rhe law require te has been si age 2 should b	Completed					24a. Was an autopsy performe	d? prior to co	opsy findings available impletion of cause of
an: rtifice tor, p	0	25. Was case referred to medical			26. Place of Death	(Check only one)	10 103	2010
ysici nis cen direc	To B	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Othe	r: 4 🗌 Nursing Ho	me 5 Residenc	ce 6 ☐Other (Specif	y)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Fime of njury 28c. Injury Work 1 □ Y	at ? ′es 2 □ No	28d. Describe how	injury occurred	
tal or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
• Hospit 124 hour • Funeral letely fills	edical		sician: To the best of my knowledge ner: On the basis of examination an and manner stated.					
To th To th comp	Me	29b. Signature and title of certifier		29c. License		29d	. Date signed (Month,	Day, Year)
) Ona	h m.D.	200 5	60 63		5/3/07	
SB		DE NAGI KANWALI	1 1	(Type, Print) SF Clan Roac	Silver	Spring	MD 2091	0
St	ate	31. Date filed (Month, Day Year)	32. Registrar's Signature	South .				

07-03399

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William F. Randolph Certificate of Death Reg. No. 1- For State 3. Time of Death 2 Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Yea Month Day May 4, 2007 0811 hrs hysician/ William F. Randolph Examiner Mec 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Lushy Patuxent Business Park water tower 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign 5. Social Security Number **Funeral** Davs Hours 07/29/1963 43 Director 222-46-5958 1X M 2 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State Yes 2 X No any Calvert Lusby 28a-f show Maryland notified at once. 10g. Citizen of What Country? filed within 72 hours after death with the Maryland 10f. Zip Code 10e. Street and Number United States 20657 13611 Olivet Road ö 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-23a 12. Was Decedent Ever in U.S. Armed Forces? Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. or items 1 Never Married 2 X Married 1 Nes 1981 Nes 1984 White Yes 2 X No specify: Divorced 16b. Kind of Business/Industry Widowed 16a. Decedent's Usual Occupation (Give kind of work done 3 15. Decedent's Education (Specify only highest grade completed) Commerical during most of working life. DO NOT use retired) Exam Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Carpenter emit. Pages I and 2 should be filed within spartment of Health and Mental Hygiene portant: If item 27 is marked offer yor other transmission of the property or other transmission. em 27 is marked other than ' traumatic event, the Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maureen O'Dougherty Francis Joseph Randolph Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13611 Olivet Road, Lusby, Maryland 20657 Carin C. Randolph (Wife) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, Cem. 5/9/07 Prince Frederick,MD Removal from State X Burial Cremation 3 2 St. John Vianney Ch. Donation 5 Other Specify: Rausch Funeral Home, 22. Name and Address of Facility permit. 1 Departm Importa 21. Signature of Fuperal Softrice Ligensee P. O. Box 600, Lusby, Maryland 20657 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a. Part I. Enter the disease, or sician Death failure. List only one cause on each line. , Medica Contact Shotgun Wound of Chest Immediate Cause (Final disease Examiner Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical AMENDED UNPENDED e attending physician for use as the burial The law requires that the death certificate be 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? signed by the a I be detached fo contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 Unknown ð σ. 24b. Were autopsy findings available 24a, Was an Completed Records, prior to completion of cause of been autopsy death? performed' 2 No 1 🗸 Yes certificate has ✓ Yes 2 page 2 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Other₄ director. Nursing Home 5 Residence 6 ✔ Other: Scene Division of Vital Be Hospital: 1 DOA examiner? ER/Outpatient 3 Inpatient 2 this 1 ✔ Yes 28d. Describe how injury occurred ۵ 28c. Injury at Work? 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury Subject shot self 27. Manner of Death After Certification: FOUND: 1 Yes 2 ✔ No Natural Pending May 4, 2007 0800 hrs Director: 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) Patuxent Business Park water tower, Lusby, MD Could not be 3 V Suicide determined (Specify) Woods 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 5, 2007 O.C.M.E. Unes 30. Name and address of person who completed cause of death (Item 23a)

6+1

ORIGINAL

Assistant Medical Examiner

200

egistrar's Signature

AND AND

111 Penn Street, Baltimore, MD 21201

Registrar

State

Ana Rubio MD.

31. Date filed (Month, Day, Year)

		For State Registrar	State	of Marylan		rtment of H		d Mental Hy	giene	2007	162	86
		Decedent's Name (First, Middle,	Last)					2. Date of D			3. Time of Dea	ıth
Physicia		George Raymon	d Roder	baugh				May 2	, ^{Day}	07	8:05 a	м
/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of D	-		County of Death	10.00	
LX		Calvert Memor	ial Hos	pital		Prince	Frede	erick		Calve.	rt	
Funeral			6. Sex	7. Age (In yrs. i	last birthday)	If Under 1 Year Months Days	If Under 24		rth av. Year)	9. Birthp	lace (State or Fo	reign
Director		171-22-3064	1 M 2 □ F	78	Yrs.	Monard Days	710010	8/31,	1928	3	PA	
pu »	-	Usual Residence of Decedent 10a. State 10b. County		10c City	v. Town or Lo	cation					0d. Inside City Li	mits
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with a or		16 B Street					0711		rog. Oniz	USA		
ING Z IZ I 3-UU30 be filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	10 B SCIEEC	12. Was Dec	edent Ever in U.	S. 13. V			? (Specity Yes or N	0- 1	4. Race - Americ	an Indian,	
fter d	듄	1 ☐ Never Married 2 🕅 Marrie	Armed F	orces? 2 ☐ No				? (Specity Yes or N Puerto Rican, etc.)		Black, White,	etc.	
OUCSO hours af tural", or	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive	1	1□Yes 2XINo	Specify:			Specify: Wh	ite	
72 ho 72 ho natur dical E	ted	15. Decedent' (Specify only highes				lent's Usual Occup kind of work done of		working	16b. Kin	d of Business/In	dustry	
thin 7	ap l	Elementary/Secondary (0-12)	 	(1-4or 5+)	life. I	DO NOT use retired	1)	working			_	
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be fill tal H d oth even	Be	17. Father's Name (First, Middle, L	.ast)					Name (First, Middle		Surname)		
Via ould Men marke	은	William Rode			T			erine O				
Viar 12 sh n and r is m		19a. Informant's Name/Relationsh	, , , ,			-		or Rural Route Num	_		Code)	
ire, INIATYIANG ZIZIO-UU3O s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Health and Mental Hygiene is the file of the state of the state of the state of the file of the state of the file of th		Sadie Rodenb	augn/Sp			sition (Name of	LOT	hian, M		ation - City or To	own State	
ages nt of l		1 ☐ Burial 2 X Cremation		State	emetery, crer	natory or other plac	· i	/ / / 0007				
Dantimor bermit. Pages Department of mportant: If it any injury or o		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Che		ake Cren 2. Name and Addres		4/2007		tsville		
Dallimore, Mis permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra		1 / / / / / / / / / / / / / / / / / / /						Raymond inkirk,			, P.A.	
	\vdash	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the deatl						3734	Approximate Interval Betwee	
Physician		Immediate Cause (Final	only one cause on	each line.	7		6.1				Onset and Deat	th
/Medical		disease or condition resulting in death)	a. Due to	(or as a consequ		elspat	N.A.					
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AL PARTS	Je.	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Dus to	(or as a conseq	uanca ol):							
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BOX attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	1□Live	utcome pf pregna birth 2 ☐ Feta	ıl death 3 [Ectopic pregnancy Other (specify)	/		2	3d. Date of delive Month	ery Day Yea	r
the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk	nant at time of d nown	leath 5L							
COIGS, P.O. BOX of we requires that the death certific been signed by the attending should be detached for use as		Part II. Other significant conditio	ns contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to t	he cause of deat	h?
w requires been sign should be	d by	Hypertens	110					1	Yes 2] No 3 ☐ Prol	bably 4 Unki	nown
> 9 50	Completed							24a. Wa	s an	24b. Were auto	ppsy findings ava	ilable
The lar	dmc							per	opsy formed?	death?	mpletion of cause 2	e of
VITAL Iclan: 7 certificat ector, pa	a	25. Was case referred to medical					26. Place of	1 Yes Death (Check only		1 ☐ Yes	<u> </u>	
ON OF VITAL MEDING The law h. After this certificate has funeral director, page 2.	O	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Unpatient 2□	ER/Outpatier	nt 3 DOA Oth	or:	ng Home 5 ☐ Re		☐Other (Special	fy)	
ig Ph ter th	T:U	27. Manner of Death 1 □ Natural 5 □ Pending	/6.6-	e of Injury nth, Day Year)	28b. Time o Injury	f 28c. Injur Wor		28d. Describe				
endir eath. or: Af	atio	Accident investig	ation				Yes 2□No					4,70
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L		30. Name and eddress of person	who completed car	use of death (Iten	n 23a) (Tyne		- 0/1	1 1		1 2/0	/	
		Manoi Mathur,					05, Pi	r. Frede	rick	, MD 2	0678	
Sta	te	31. Date filed (Month, Day, Year)	32.	Registras Signa	ature	Sparte				··		
Registr	ar	MAY	4 2007	- Charles	as St	MONEC						

			1 - For State Registrar	State of M	arylar			nt of H te of L		nd M	-	jiene 10g. No.	2000	15287	
ı	Physici /Medie		1. Decedent's Name (First, Middle, La George		vid		Re	nold	s, Jr		2. Date of Dea Month May 2,	Day	Year	3. Time of Death 6:30 A M	
	Examir		A Company of the second					Cumb	Location of	d			4c. County of Death Allegany		
	Funeral Director		5. Social Security Number 6. S 219-07-9068	FRA OFF	ge (In yrs. 87	Yrs.	Month:	er 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 12/02/		Co	thplace (State or Foreign cuntry) cyland	
	Maryland	tor	10a. State 10b. County MD Allega	ny	10c. Ci	ty, Town or Lo	ocation perla	.nd			* ***			10d. Inside City Limits 1 Yes 2 No	
	be filed within 72 hours after deeth with the Maryland ital Hygiene. bd other then "natural", or Iteme 23a or 28a-f show event. It a Medical Examinar must be notified.	Funeral Director	10e. Street and Number 10609 Hinkle	Road, SE	-	. C		ip Code		:-0./0			USA 14. Race - Ame		
036	ours after d all, or item Examinari	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces 1 XYes 2 If Yes, Give Year or Dates:	?	39-		ecify Cubai	Specify:	Puerto F	cify Yes or No- Rican, etc.)		Black, White Specify:		
1215-0	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Elementary/Secondary (0-12)		5+)	(Give	kind of v DO NOT	use retired,	luring most)				nd of Business	Andustry	
Maryland 21215-0036	ould be filed within Mental Hygiene. arked other then 'atic event, Ita Ma	To Be Co	17. Father's Name (First, Middle, Last, George	David		Certi Reynol				's Name	(First, Middle,			overnment nd	
	d 2 sh th and 7 ie m traum	-	19a. Informant's Name/Relationship (Juls R. Wood / So										r Town, State, .		
Baltimore,	permit. Pages 1 and Department of Heali important: if item 2 any injury or other ance.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.				nd Ci	emate	ory 05	5/02,		Cun	cation - City or aberlan	d, MD	
Balt	permit. Depart Import any inj		21. Signature of Puneral Service Licer	Vol-	2	4	404 1	Decati	ır Str	reet	, Cumbe	rlar		Home, P.A. 21502	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ine.						respiratory ari	est,		Approximate Interval Between Onset and Death	
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8760,	ate be executed thysicien and the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.													
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					Ectopic pregnancy Other (specify)				4	23d. Date of delivery Month Day Yea		
	The law requires that the de ste has been signed by the a page 2 should be detached f	ρ	Part II. Other significant conditions of	ontributing to death t				cause give	n in Part I,			bacco u es 2[o the cause of death?	
Division of Vital Records,		Completed	Azztiemens framentin											completion of cause of	
<u>₹</u>	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or				
on of	Attending Physic death. Sctor: After this by the funeral dispersion	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju		28b. Time o Injury		28c. Injury Work	at ?	2	ome 5∭ Residence 6 □Other (Specify) 28d. Describe how injury occurred			icity)	
Divisi	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fan building, etc. (Specify)											ural Route Number,	
	he Hospit in 24 hour he Funera pletely fille	Medicai ((Check only 2 Medical Exar	ysician: To the best niner: On the basis of and manner si	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	e, date and inion, death	place, a	nd due to the c d at the time, c	ause(s) late and	and manner as place, and due	s stated. e to the cause(s)	
)	ia/IVA	≥	29b. Signature and title of certifier	KIND			2	D42	number 2054		2		e signed (Mont		
	nes		30. Name and address of person who Gregg C. Do					n Dri	lve, C	Cumbe	erland,	MD	21502		
	Sta Registr		31. Date filed (Month, Dey, Year) MAY 0 3 200	32. Regist	ar's Sign	ature And	ork; c								

			For State Registrar	of Maryland / Depa	artment of Health		tal Hygiei	-2111111	16288	
	Dhuciai	22	Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death	
	Physici /Media		Theresa A. Ryan			M	ay	4 2007	11:53AM	
	Examir	er	4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location	on of Death		4c. County of Death Worces te	r	
	Funeral		104 Pine Street 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		der 24 Hrs. 8. [Date of Birth		place (State or Foreign	
	Director		218-50-2040 1□ M 2□ MF	58 Yrs.	Months Days Hour	rs Min. Fe	Date of Birth Month, Day, Ye b. 26,	1949 DE		
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				IOd. Inside City Limits	
	Mary -f ehc	ţo	MD Worcester	Ber	lin				1 X Yes 2 □ No	
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?	
	ath wi	raic	104 Pine Street		21811			USA		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "natural", or items 23a or 28a-f ehow other treumatic event, the Medical Eventral must be conflided at	by Funerai	1 Never Married 2 Married 1 7 Fes.	s 2 🔯 No	Was Decedent of Hispanic If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Speci		Yes or No- n, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.	
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d 2	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)	пан	rdresser	other's Name (Fir		Cosmetolog den Sumame)	J.Y	
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Maryland 21215-0036	2 should be filed with and Mental Hygiene ie marked other the eumatic event, Ine		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Num				Code)	
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Baltimore,			4 □Donation 5 □Other (Specify) 21. Signature of Foneral Service Licensee	cape nem	2. Name and Address of Fa			ankford, D Funeral F	ome	
Ã	permit. Departn imports eny inju		futt / for	10	08 William St	., Berl	in, Md.	21811	Ome	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Due	at caused the death. Do not en n each line. to (or as a consequence of)	ter the mode of dying, such	as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death	
8760,	rate be executed shysicien and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of): to (or as a consequence of);						
O. Box 6	the death certific by the ettending p ached for use as i	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year	
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Vita	Physicien: this certific ral director,	Be	25. Was case referred to medicat examiner?			lace of Death (Cl				
ion of	ding After fune	ation: To	1 Tes 2 10	□ Inpatient 2 □ ER/Outpatie Ite of Injury Ionth, Day Year) 28b. Time of Injury		28d.	Describe how in	e 6 ⊡Other (Speci ntury occurred	fy)	
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	To the Hospitel or within 24 hours effer to the Funeral Dir completely filled in	Medicai	(Check only 2 Medical Examiner: On the	the best of my knowledge, deal e basis of examination and/or in anner stated.	th occurred at the time, date ivestigation, in my opinion, o	e and place, and death occurred a	t the time, date	and place, and due t	o the cause(s)	
	With To 1	Σ	29b. Signature and title of certifier	mo-	29c License numb	85	29d.	Date signed (Month,	Day, Year)	
P	13		Anthony Verella C	duse of ceets (Item 23a) (Type	phy Vace	Seri	in A	10 218	7[
	Sta "Regist		MAY 0 7 2007	Marce J. A.	porte					

State of Maryland / Department of Health and Mental Hygiene | 1 | 7 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month May ELEANOR CONWAY SMITH 11, 11:50A M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2329 Jerry's Road Street Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 12/9/ Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🖫 F Hours 87 Yrs. 155-05-3007 Director New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23 and 28 and 28 and 28 and 29 and 20 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Director Harford Street 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2329 Jerry's Road 21154 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. δ Specify. 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk New Jersey 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) Be ဂ George Ellie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2329 Jerry's Rd. Marsha Baumeister (Dau.) Street, MD. 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation 5/15/2007 Hampstead, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Travice Licenses 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A 23a. Part1. Enter the disease, or complications that caused title death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heratama disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 1 ☐ Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probebly 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 25 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely tilled in by the ful investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032543 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Grambon6 6701 Charles 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar doeses?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:25 A M April 26 2007 MELVOYD STRINGFELLOW /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (Month, Day, May 17 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F '1904 Chester, SC 102 579-50-1307 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10b. County Maryland | Prince George's Fort Washington 1 X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 United States 2613 Holly Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 🔀 No Specify: ۵ 3 ☐Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Williams Mose Chisholm ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2613 Holly Drive, Fort Washington, Maryland 20744 Deborah Goggins/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/5/07 Lincoln Memorial Cem. Suitland, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Fune al Service Licensee W 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed No certificate l 1∐ Yes Physician: 25. Was case referred examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 ☐ **D**OA ို 1 ☐ Yes 2 npatient 2 ER/Outpatient this After this funeral o 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: Hospital or Attending 5 Pending investigation uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide thin 24 hours a the Funeral C terifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 0

State Registrar

(Month, Day, Year) MAY 0 4 2007

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10c, e.f. per / the 8868 6-19-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ANNIE DELORIS BRYANT (SLADE) May 2007 17:46 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye Sept. 24 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Year) 4 1933 Tarboro, NC Months Days 244-48-5650 73 Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Upper Marlboro 1y∑Yes 2☐No Maryland -Rockville Montgomery 10e. Street and Number 9920 Stonewood Court 10f. Zip Code 10g. Citizen of What Country? 20772 20853 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: Black 3 ☐ Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher 4 Education Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alonzo Slade Elizabeth Bess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Vernice S. Carney/Sister 14304 Blackmon Drive, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Slade Family Cemetery May 8 2007 Tarboro, No. Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service 200 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lis only one cause on each line. nmediate Cause (Final complete Small disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Y*e*ar 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at

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72 hours after death

and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than "

permit. Pages 1 and 2 s
Department of Heath ar
Important: If item 27 is
any Injury or other trau

Baltimore, Maryland 21215-0036

Director

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O. Box 68760

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Division or Vital Records,

Examine Physician/Medical 2 Completed Be ၉ Medical Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an Were autopsy findings available prior to completion of cause of autopsy prior to comp death? perform 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) D0064801 05/02/2007

State

Hospital or Attending

31. Date filed (Month, Day, MAY 0 4 2007 서보7503 Suratts Road, Clinton, Maryland 20735 32. Registrar's Signat

30. Name and address of Person who completed cause of death (Item 23a) (Type, Print)

Registrar

			For State Registrar	State of N	Marylan				lealth a	and M		giene Reg. No.	007	162	92
			Decedent's Name (First, Middle,	Last)	-						2. Date of Dea	ath		3. Time of I	Death
и	Physicia		Robert	Parker	Sr	nead					Month May 4	, 2007	Year 7	6:22 a	М
ÿ.	/Medic Examin		4a. Facility Name (If not institution,			icuu	4b. Cit	y, Town, or	Location o	f Death		•	nty of Death		
	Ename	•	Calvert Memori	al Hospit	al		Pr	ince	Frede	eric	k	Ca	lvert		
	Funeral			5. Sex 7.	Age (In yrs.	last birthday)	If Und Months	er 1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Yea <i>r)</i>	9. Birth Cor	nplace (State or untry)	Foreign
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Maryland 21	2 should and Men is marke aumatic		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mail	ing Addre	ss (Street	and Numbe	er or Rura	I Route Numbe	er, City or To	wn, State, Z	(ip Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the Marylan Item 27 is marked other than "naturel", or Items 28s or 28s-1 show other traumatic event, Ite Medical Examinar must be notified at		Mildred D. Snead	l, wife		_			Ct.,				<u>-</u>	D 20714	<u> </u>
altimore,	Pages 1 nent of He int: if iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Str	ate C	Place of Disp cemetery, cre	matory o	r other plac			Date		on - City or		
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Ba	permit. Pages Department of Important: If it eny injury or o		21. Sign this of Funeral Service Li	censee	oeka	el 83	2. Name 325 M	and Addres It. Ha	armon	^y Rau: v La:	sch Fun ne, Owi	eral H ngs, M	Iome, ID 20	P.A. 736	
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Ë	Physician: The this certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		TED/Outcotic	ent 3□	DO A Oth	000		h <i>(Check only c</i> ime 5 ☐ Resi		Other (Con	6.1	
ō	Phys rthis sral dii		27. Manner of Death	28a. Date of (Month,		28b. Time		28c. Injur Wor	4 140		28d. Describe			ciry)	
Ö	Attending Physician: ir death. ector: After this certifics by the funeral director.	atloi	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	М		rk? Yes 2 ☐	No					
Division of Vital Records,	or Attandi after death. Director: A in by the fu	Certification;	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of	f Injury - At h	nome, farm, s	treet, fact	ory, office			28f. Location (City or To		umber or Ru	ural Route Num	ber,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the b	est of mv kn	owledge, dea	ith occurr	ed at the tir	me, date ar	nd place.	and due to the	cause(s) and	d manner as	stated.	
	Hours 1 24 h	edical		xeminer: On the bas and manne	is of examina)
	To the To the Comp	Ě	29b. Signature and title of certifier				1	29c. Licens						h, Day, Year)	
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	/		30. Name and address of person v		.1 .			^						/ -	n
	0+1		ADEES JABE 31. Date filed (Month, Day, Year)	R 100	HOSP gistra		0.	PR	INCE	FR	EDERI	CK,	MD	2067	Ø
1	Sta Regist	ate rar	MAY	7 2007	Jon or orgin	A AR	1	rack!	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#29D Per Phy. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AACO HEALTH Dept. 5/3/07 CMH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 **Physician** 29, April 10:08 Αм Nancy Ann Selby /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Ye If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🕶 F 14, 73 Maryland Director 220-28-6393 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Directo Prince Georges Bowie Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 12611 Heming Lane 20716 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Supply Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Ellen Lawson ပ Ambrose Edward Partin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7715 Schooner Drive Lusby, MD 20657 Renee Davis/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Bunai 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 5/1/07 Alexandria, VA 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Lices 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? 1 ☐ Yes 2 ☐ No certificate 2 1 No Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 To the Hospital or Attending 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 4/29/07 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 31. Date filed (Month, Day, Year gistrar's Signature State 3 2007 Registrar

amend line 17 per fd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	and 19a pe 10o 5-11-0			Pleas	se Type or Pri					•		•	
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			State Registrar 1. Decedent's Name	e /First Middle	(act)		Ce	rtificate o	Death	2. Date of	Reg. N	10. <u>CUU</u>	3. Time of Death
в	Physicia	_			hael Scord	os				APRI		7 4007	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~
	/Medic Examin	_			give street and number			4b. City, Town	, or Location of D			c. County of Deat	
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	Funeral		5. Social Security N		6. Sex 7. A 1 XM 2 F	ige (In yrs. la	s <i>t birthd</i> ay) Yrs.	If Under 1 Yea Months Day		Min. 8. Date of (Month, 09/01	Birth <i>D</i> ay, Yea	9. Birt Co	hplace (State or Foreign untry)
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	yland how at		10a. State	10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
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	with the a or 2 be no		10e. Street and Nu		_			10f. Zip Code 20706			USA	Citizen of What Co	ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	9213 5th	Street	12 Was Deceden	t Ever in U.S	. 13.			n? (Specify Yes or Puerto Rican, etc.)		14. Race - Ame	
မွ	after c or iter niner		1 Never Marr	ried 2 Marrie] No		If Yes, specify Control 1 ☐ Yes 2 ☐ XN		Puérto Rican, etc.)		Black, White	e, etc.
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<u>ğ</u>	a filed al Hyg other	BeC	17. Father's Name	(First, Middle, L	Last)				18. Mother's	Name (First, Mid	dle, Maide	en Surname)	
/lar	wuld be Menta arked	To E	Michael R	Kosta So	cordos				Ange1	a Caloge	na		
Maryland 21215-0036	S D E E		19a. Informant's N					_		or Rural Route Nu Road Layt			
	1 and Health Sm 27 ther t		20a. Method of Dis		os/ Daughte					Date Date	_	Location - City or	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai		1 ∰Burial 2		3 ☐Removal from Stat	e ce	metery, cre Mary	osition (Name of ematory or other p Land	nlace)	5/02/2007		eltenham	
) =	permit. Pag Department Important: I any Injury o		21. Signature of F			rvet		Cemete:		Robert E	,		
ä	Dep Imp		1/1	11/1			1	.6000 Am	napolis	Road Bow	ie,	MD 20715	
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7	/Medical Examiner		resulting in death)			s a conseque	ence of):	ENAL	TA II	UOF			
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	uted d ansit	Examine	cause. Enter Under Cause (Disease or that initiated events	rinjury	SEF	TIC	SH	rock					
ó,	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Еха	resulting in death)	Last	Due to (or a	ıs a consequ	ence of):						
876	icate be physicia s the bu	lical			d	_							
Box 6876	death certifica attending ph I for use as t	Physician/Medica	IF FEMALE:		23c. If yes, outcon	ne of pregnan	icv					23d. Date of de	livon
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	res tha igned be det	by P	Part II. Other signi	ificant conditio	ons contributing to death	but not resul	ting in the I	underlying cause	given in Part I.				o the cause of death?
ord	w require been sig	ted								'	∐ Yes	2 No 3 P	
3ec	elaw hasb je2sh	Completed								— 24a. W	/as an utopsy erformed:	24b. Were at prior to death?	utopsy findings available completion of cause of
a	n: Th ficate rr, pag		25. Was case refe	red to medical					00 81	1□ Ye	s 2 🛂	No 1 ☐ Yes	3 2 □ No
Ξ	nysician; The Is nis certificate had I director, page 2	o Be	examiner?	√No No	Hospital: 1 Vinpa	ntient 2□E	R/Outpatie	ent 3 DOA	Other:	of Death <i>(Check on</i> sing Home 5 ☐ R		6 □Other (Spe	acifu)
0	ding Phy n. After this funeral c	n: To	27. Manner of Dea	ıth	28a. Date of Ir		28b. Time Injury		njury at Vork?			jury occurred	(Say)
Sior	tendin leath. tor: Af the fur	atio	1 Matural 2 Accident	5 ☐ Pending investig	jation			M 1	☐ Yes 2☐ No				
Division or Vital Records,	or Att fter de Directa in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	determi	:nod 20e, Place of I	njury - At hor etc. (Specify)	ne, farm, s	treet, factory, offi	ce	28f. Location City or	n (Street Town, St	and Number or R ate)	ural Route Number,
	pital ours a meral C	Ce	29a. Certifier	1 Certifyin	g Physician; To the be	st of my know	/ledge, dea	ith occurred at the	e time, date and	place, and due to	the cause	e(s) and manner a	s stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: v completely filled in by the f	Medical	(Check only one)		Examiner: On the basis and manner	of examinati							
	To the within 2 To the complet	Me	29b. Signature and	d title of certifier	ī			29c. Lice	ense number		29d. I	Date signed (Mon	th, Day, Year)
				Ha v	ME			MDD	53712	3		1291	07
ı	OHCH		30. Name and add	ress of person	who completed cause o	f death (Item	23a) (Type	e, Print)	LINK K	ROAD I A	RILLA	-11 MD	7 (71/-
	Sta	te	31. Date filed (Moi	nth, Day, Year)	32. Reg	trar's Signat		0000	CIVIL'	10/10/17	1411/1	MY 1-17 4	-0110
	Registi			MAY 0	3 2007	Merco	K	book	·				

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryla Huriana Baltimore, Maryland 21215-0036

Lawrence Stinchcomb

Ph /N Ex

To the Hospitel or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

1.#	1 - Stete Registrar 17, FH, TCHD, (Department of Certificate of		ntai Hygiei Reg.	2001	16298
ian ical	1. Decedent's Name (First, Middle, Last)	•				Dey Yeer 30 2007	3. Time of Death
ner	4 77 373 44 446 44 45 45 4			or Location of Death Easton		4c. County of Dea Talk	
	220-34-5686	7. Age (In yrs. last to 66	Yrs. If Under 1 Year Months Days		Date of Birth Month, Day Ye	9. Bir 1940 N	thplace <i>(St</i> ate o <i>r Foreigi</i> pu <i>ntry)</i> IARYLAND
Director	Usual Residence of Decedent 10a. State 10b. County MD TALBO		TRAPPE				10d. Inside City Limits 1 ☐ Yes XX No
al Dire	10e. Street and Number 28925-B ISLAND CRE	EK ROAD	10f. Zip Code	1673	10g.	Citizen of What Co USA	ountry?
To Be Completed by Funeral Director		Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specifican, Mexican, Puerto Rico Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify: WH	
Completed	15. Decedent's Educat (Specify only highest grade c Elementary/Secondary (0-12) 1.2	ion 16 ompleted) College (1-4or 5+)	Ga. Decedent's Usual Occi (Give kind of work don life. DO NOT use retir EXECUTIVI	e during most of working red)	16b	. Kind of Business	
Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	First, Middle, Maid		
5	NORMAN STINCHCOMB			MARTHA BU			
i	19a. Informant's Name/Relationship (Type, MATTHEW STINCHCOMB		9b. Mailing Address (Stree 9 SOUTH ELL]				
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem	noval from State	of Disposition (Name of tery, crematory or other pl	1		Location - City or	Town, State
	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	CHESA	PEAKE CREMATE 22. Name and Add FELLOWS F		NEWNAM	STEVENSVI FUNERAL	
cal Examiner	cause. Enter Underlying Cause (Disease or rinjury that initiated events resulting in death) Last	Due to (or as a consequence					
Med	IF FEMALE: 23c.	M					
ysiclan/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of del Month	ivery Day Year
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			Registrar 1. Decedent's Name (First, Middle, Last)		Centili	cate of De	eatri	2. Date of Dea	leg. No.		3. Time of D)oath
	Physici			ston Ctonto				ADNIL	Day	2007	1733	
	/Medi Examir		Robert Sylves 4a. Facility Name (If not institution, give s			City, Town, or Lo	ocation of Death	Apric	4c. County		1,00	
			Dorchester G	eneral Hosp	ital	Camb	vidae		Don	ches	ster	
	Funeral		5. Social Security Number 6. Sex	M 2□E	Mo		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10-17-1	Year)	9. Birthp	lace (State or i	Foreign
col	Director		Usual Residence of Decedent	61	Yrs.			10-17-1	945	Mary		
0 /	yland Now		10a. State 10b. County	10c. Ci	ity, Town or Location	n				1	0d. Inside City	Limits
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1/	or 28	Director	10e. Street and Number		10	f. Zip Code			log. Citizen of	What Cour	ntry?	
2	ath w		409 Robbins Far			21613			USA			
0	s after death with the Marylan s or Items 23a or 28a-f ehow aminet must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	2. Was Decedent Ever in U Armed Forces?		Decedent of Hispa , specify Cuban, I	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- lican, etc.)		ce - Americ ck, White,		
Œ E	within 72 hours atter death with the Maryland with in 72 hours atter death with the Maryland ane. Itan "netural", or Items 23a or 28a-f ehow ita Madigal Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	1 DYYes 2 □ No If Yes, Give Year or Dates:	1 🗆 Y	es 2 No 5	Specify:		Specif	у: В1.	ack	
	72 hours	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's	Usual Occupation	n na most of workis		16b. Kind of B			
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0	D 00 2	S	17. Father's Name (First, Middle, Last)	2	Securi	Lty Guar		Cima Mindella		spit	a1	
F	d be f ental h	To Be		a.t.a.n		10	B. Mother's Name Edna	(First, Middle,	Wilson			
ANTC	and yiailla K. I.K. 2 should be filed within and Mental Hygiene. ie marked other than aumatic event, II.a.Ns	F	Lester Star 19a. Informant's Name/Relationship (Type	nton pe, Print)	19b. Mailing Ad	dress (Street and	Number or Rural	Route Number			Code)	
	5 n 4 h 5		Cynthia Stanton	n / wife	409 Ro	bbins F	arm Road	, Cambr	idge,Ma	ary1a:	nd 2161	.3
	Dalliffice, Dermit. Pages 1 ar Department of Hea mportant: If Item iny injury or oths		20a. Method of Disposition 1 ABurial 2 Cremation 3 Re		Place of Disposition cemetery, crematory	(Name of			20c. Location			
VI	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify)		Maryland Veterans			-2007	Hurlock	.Mar	yland	
Ì	Dalliffication of permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other ance.		21. Sign (tur. Fun ral Service License	South (a)	I Be	ne and Address of	ith Fune	ral Hom	ie .	- 40 11111	01610	
1			23a. Part Lenter the disease, or complic	cations that caused the deat			Street,			y Land	Approximate	
	Dhusisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.				respiratory arr	651,		Interval Betwee	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		114091	5			1	1ears	
	Examiner		Conventinity list conditions	Alcohol	ic Hel	atitis				2	male S	
	po iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					7		
	xecute and ii-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	ruence of):							
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0.9		edical	a.									
2	eath certifi attending	Physician/M	230. Was decedent pregnant	Bc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete		pic pregnancy			23d. Da	te of delive	ry	
	e deal	sicie	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of d		er (specify)			Mo	onth	Day Ye	ar
	res that the de signed by the a be detached f		9 ☐ Unknown Part II. Other significant conditions conf		unition in the constant		. 6	DO Dide		21		
Division of Vital Becords	The law requires that the death certifute law requires that the death certifute has been signed by the attending bege 2 should be detached for use a	d b	Chronic Benc	Fully of	sulting in the underly	ing cause given ii	п Рап I.	1 Ye	oaccouse cont es 2. ŽNo		e cause or dea ably 4 ⊟Uni	
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<u>a</u>	sician: Th certificate rector, peg	0	25. Was case referred to medical			26	6. Place of Death			1 🗆 Yes	2□ No	
>	Physician: r this certific	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: Inpatient 2	ER/Outpatient 3[Othor	4 Nursing Hom			er (Specify	·)	
2	ding Pt h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe ho			,	
i.	Attending r death. octor: After	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М		2 □ No					
<u> </u>	or All	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa fy)	ctory, office	21	3f. Location (St City or Town	reet and Numb n, State)	er or Rura	Route Numbe	er,
_	To the Hospital or Attendi within 24 hours attendeath. To the Funeral Director: A completely filled in by the fu		29a. Certifier Tertifying Physi	cian: To the best of my kno	owledge, death occu	rred at the time	date and place, ar	nd due to the co	use(s) and ma	nner as et	ated.	
	ha Ho n 24 h ne Fui	Medical	(Check only 2 Medical Examin one)	er: On the basis of examina and manner stated.	ition and/or investig	ation, in my opinio	on, death occurre	d at the time, di	ate and place,	and due to	the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	01		29c. License nu	ımber	2	9d. Date signer	d (Month, L	Day, Year)	-
			· uneu	Nen	all	H5	1743		4/2=	3/07	_	
ć	AV+		30 Name and address of person who com		n 23a) (Type, Print)	7 7	CI	0.	Jan 1	1	(0)	(1)
1	Sta	te.	31. Date filed (Month, Day, Year)	3 Registrar's Signa	ture 4	2 174	m 11	Can	wide	14	0/0/16	013
	Registr		APR 2 6 2007	Bleeve &	X does							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Eliza Louise Spickler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 213-82-8198 1 □ M 2 🛛 F 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County MD State Washington Williamsport Director 10e. Street and Number 16505 Virginia Ave. 10f. Zip Code 21795 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Smith Shupp Bertha Mae Staley 19a. Informant's Name/Relationship (Type. Print) Donald Spickler son 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Immediate Cause (Final disease or condition resulting in death) **Physician** Severe /Medical Due to (or as a consequence of): Examiner lostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9731 Lock Tender Lane Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Tabor Cemetery May^{Date}9, 20c. Location - City or Town, State Clear Spring, MD 2007 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD 21722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ly art failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 40 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 🗌 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2. Date of Death

8. Date of Birth 8 Month 2 ay 1 9 1 2

Month

Day

Year

2007

Washington

Birthplace (State or Foreign
 MSuntry)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

4c. County of Death

10g. Citizen of What Country? U.S.A.

Specify:

16b. Kind of Business/Industry

residence

14. Race - American Indian,

white

Black, White, etc

nding physician and use as the burial-trar P.O. Box 68760. or Vital Records,

Physician/Medical

Completed by

Be

ဥ

Certification:

Medical

IF FEMALE:

23h. Was decedent pregnant

1 ☐ Yes 2 ☐ No 9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

1 Yes 2 100

27. Manner of Death Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending nhysician and in by

Division

01H-5

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

JUDITH MBAOUA

MD 251 B. Antietom St. 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M	aryland		artmen rtificat			and M		giene leg. Na.	007	162	99
			Decedent's Name (First, Middle, Last)							1	2. Date of Dea	ıth	0 1	3. Time of De	eath
1	Physici /Medic		Richard Daniel	Shank							Month	5 Day	2007	9:55	АМ
	Examir		4a. Facility Name (If not institution, give s	treet and number	")		4b. City,	Town, or	Location o	of Death	· · · · · · · · · · · · · · · · · · ·	4c. Co	unty of Death	1	
			12070 Kemps Mil					_	amspo					ington	
	Funeral		5. Social Security Number 6. Sex	7. A	ge (In yrs. las		If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	, Year)	9. Birth Cor	nplace (State or F untry)	Foreign
ig.	Director		218-24-1834 'X' Usual Residence of Decedent		78	113.					eb. 14	, 1929	, ,	Maryland	1
	yland iow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City	Limits
	Marian	ţo	Maryland Washing	ton			Will	liams	port					1 ☐ Yes 2	. X No
	or 28	Directo	10e. Street and Number				10f. Zip				1	10g. Citizen	of What Co	ıntry?	
	23a		12070 Kemps Mil	I Rd.				217	95				USA		
	tema	Funeral		 Was Decedent Amed Forces 	7 105	13.	Was Deced If Yes, spec	dent of His	spanic Orig n, Me xican	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)		Race - Amer Black, White		
36	', or l	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⚠ Yes 2 ☐ If Yes, Give Year or Dates:	105		1 ☐ Yes	2 X №	Specify:			Spi	ecify:	White	
8	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or Itema 23a or 28a-1 show event, the Medical Exeminar must be natified at	edt	15. Decedent's Educ			16a. Dece	dent's Usua	al Occupa	ıtion			16h Kind d	of Business/I	White	
215	within 72 ene. than "na ne Modil	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give	kind of wo	rk done d	lurina most	t of workir	ng				
21	giene grene grene	ĕ	11	College (1-40)	3+)	Tow	Motor	• 0pe	rator	^		Whole	sale	Auto Par	·ts
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sur	name)		
<u>ya</u>	should be nd Menta marked imatic ev	_o	Earl Clifford Sh	ank					He	elen	Irene	Davi	S		
Baltimore, Maryland 21215-0036	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Typ	ne, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	or Or Rura	l Route Number	r, City or To	wn, State, Z	ip Code)	
e,	1 and lealth sm 27 ther t		Louise Shank - W 20a. Method of Disposition	ife	20h Plac	12070 e of Dispo	Kemp	s Mi	11 Bo	bad _	Williaa ate	sport	on - City or 1	yland 21	795
Jor	ages or of		1 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cem	netery, crer	natory or o	ther place							
ij	it. Printme		4 ☐ Donation 5 ☐ Other (S, , , ,) 21. Signatur uneral Service (cer se		Gree	n l awn					2007 W	VIIIIa	mspor	t, Maryl	and
Ba	permit. Pag Department Important: I any Injury o		Mass M. C.	la_							St. Wi	lliam	sport	, MD 21	795
	Physician		23a. Part1. Enter the disease, or complic shock or heart failure. List only on Immediat Cause (Final disease or condition	ations that cause e cause on each l	ed the death. line. { AUN	X	·	2	s, such as					Approximate Interval Betwee	
	/Medical		resulting in death)	Due to (or as	s a consequer		0		0	1	rorning	7		14	
	Examiner		Sequentially list conditions, b	_/XI	CAT	tic	(4/	LUNE	(/	uch	ronnig	11/1	snow	Teny	P
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ <i>e</i> r	nce of):								~	
	xecut and al-trar	хап	that initiated events c. resulting in death) Last	Due to (or as	s a consequer	nce of):									
8760,	death certificate be executed a attending physicien and d for use as the buriat-transit	Sai													
89	ificate g phy as the	edicai	·								-				
Вох	eath certific attending p	Physician/M	230. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pr	0.00000000				23d.	Date of deliv	ery	
		sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (sp						Month	Day Yea	ar
P.0.	that the de led by the a detached f	Ph	9 Unknown												
	8 2 8	Ď	Part II. Other significant conditions cont	inbuting to death t	but not resulting	ng in the u	nderlying c	100-		2.1	-			the cause of deal	
orc	w requir been si should I	ed	THE COM	X	- 17	500	100	51/ /	LEE CE	100	1 🗆 Ye	es 2 N	o 3∐ Pro	bably 4 Unk	vn
of Vital Records,	e law has b	Completed	14CMONTAG	1)/504(6	> 11	400	170	3 lon	V		24a. Was a autops	sy	prior to c	opsy findings ava ompletion of caus	arlable se of
<u>~</u>		õ	A			•					1 Yes	2 XNo	death? 1 ☐ Yes	2 □ No	
<u> </u>	ttending Physician: The loath. tor: After this certificate hat the funeral director, page	Be	25. Was case referred to medical examiner?	ospital:				Othe	-		Check only on				
ō	Phys r this ral di	 T	1 Yes 2 No	1 ☐ Inpati 28a. Date of Inju		VOutpatien Bb. Time of		A	4 🗆 Nui		ne 5 Reside			ify)	
O	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury	м	8c. Injury Work 1 ☐ Y	? ′es 2 □ N		od. Describe in	ow infairy oc	cuiled		
Division	or Attend after death Director: , in by the f	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At home	e, farm, str	eet, factory						ımber or Rui	al Route Number	ır,
á	al or A s after al Direct	Certification:	4 Homicide	building, e	tc. (Specify)						City or Towi	n, State)			
	To the Hospital or Attending Physician: while 24 hours after deals as after deals. To the Funeral Director. After this certifica completely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Physic (Check only 2 Medical Examination)	ician: To the best	t of my knowle	edge, death	occurred a	at the time	e, date and	d place, a	nd due to the c	ause(s) and	manner as	stated.	
	the hin 24 the F	Medi	110	and manner st	tated.			_		Joodine					
\	Z wit	-	29b. Signature and Attle of Certifier		Alle	C	290	License	Tumber 1	1	2	ed. Date sig	gred (Month	Day, Year)	
			mul /	AMCY	1.421	1(1)		UI	100)		7 \	1/20	()	
31	4-4+1		(TEDHAN) (- 1/10	TOVEN	death (Item 2:	3a) (Type,	174 /	3 1	Ju-	46	ACCULT	(eun)	Ma	(2174	10
	Sta	te	31. Date filed (Month Pay Year) WAY 08 200	32. Figist	rar's Signatur	е		W /	1-0/	. (/	/- 1/1	,	6	- () (U
	Registr		MAT U 8 200	31 /	m A	. 1	1.80								

State Registrar Hospital, 600 North Woife Street

Johns Hopkins

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

he

Mathelier

Day.

Year)

0 4 2007

Hansie

31. Date filed (Mo

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month PATRICIA WINIFRED THOMPSON 5-2-07 6:05 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14413 JAYSTONE DRIVE SILVER SPRING MONTGOMERY . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 ☐ M 2 🖫 F Yrs Director 118-34-3846 9-20-44 **NEW YORK** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Director 1X Yes 2 □ No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14413 JAYSTONE DRIVE Items 23a 20905 U. S. A. o filed within 72 hours after death all Hygiene.
other than "natural", or Items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSING INSPECTOR DISTRIC OF COLUMBIA YEARS permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Importent: If Item 27 is marked oth any july or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be ALBERT ပ LINDER THELMA HUNTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20905 19a. Informant's Name/Relationship (Type, Print) THOMPSON-HUSBAND 14413 JAYSTONE DR. SILVER SPRING, MD WILLIAM B. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State GATE OF HEAVEN 5-7-07 4 ☐ Donation 5 ☐ Other (Specify) SILVER SPRING, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY SPANGLER F. H. 524 - 8TH ST., N. E. WASH., DC 20002 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lor as a consa uence of Examiner nding physicien and use es the buriel-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No the after death 3 Suicide 6 Could not be determined 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check ont one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D00646#5 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wrohlewski MD 1355 PICCATODY Rockwille Benevieve 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 4 2007 Registrar

			For State Registrar	State	of Marylan		artment of				giene Reg. No. 2	10.7	16300
			Decedent's Name (First, Mide	dle, Last)				. 200		2. Date of Dea	ath	F U 1	3. Time of Death
	Physici /Medi		Doris	Viola	Tedde	er				April	30 20	07	11:25 A M
	Examir		4a. Facility Name (If not instituti	on, give street and nu	mber)		4b. City, Towr	n, or Location				y of Death	
		4	8601 Temple H					Hills			Princ	ce Ge	orge's
100	Funeral Director		5. Social Security Number 215–26–3235	6. Sex 1 ☐ M 21 ☐ F	7. Age (In yrs. 7 5	last birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day	h /, Yea <i>r)</i> 1931	Cou	place (State or Foreign intry) vland
	pu: »		Usual Residence of Decedent 10a. State 10b. Count	24	10c Cit	y, Town or Lo	nation						
	laryla shov ed at	5		ice George		y, rowinor Lo		e Hills	-				10d. Inside City Limits 1 ☐ Yes 2 No
	the N 28a-f	Director	10e. Street and Number	ice deorge	5		10f. Zip Code		J 		10g. Citizen of	What Cou	
	with 3a or t be i		8601 Temple H	Hill Boad	Tot 36		207				USA		nu y :
	ms 2: mus	Funeral I	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Decedent of If Yes, specify C		rigin? (Spe	cify Yes or No-			can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 □ Never Married 2 💆 Ma 3 □ Widowed 4 □ Divorce	If Yes Gi	2 ∑ No ve		if Yes, specify C 1 ☐ Yes 2 💢 N			Rićan, etc.)	Speci.	ick, White,	
21215-0036	2 hou latura ical E	ted	15. Decede	nt's Education		16a. Dece	dent's Usual Occ	cupation			16b. Kind of E		ite
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	ed wii ygien ier th t, the	5	7			home	emaker					home	
Maryland	be fill d oth even	Be	17. Father's Name (First, Middle							(First, Middle,	Maiden Surna		
	ould d Mer narke natic	^L	Ralph Samu		erton	401 14 15		1	iola				tinnett
Mai	d 2 sl th an 7 is r traur		19a. Informant's Name/Relation		7		g Address (Stre						20740
	Heal Heal tem 2		Lawrence H. Te	eaaer, nusi	20b. P	lace of Dispo	Temple sition (Name of	i		Lot 36,	TempLe 20c. Location		
JO L	ages ent of t: If ii		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (State		natory or other p	_ ′ i) F 0.4	2007		•	•
Baltimore,	nit. F artme ortan injur		21. Signature of Funeral Service		/MC.		ny Ceme				Owings,		
m	permi Depar Impor any ir		1 William	- R. C	(10	_			Na				me, P.A. MD 20736
Ų.			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that of	caused the death	n. Do not ent	er the mode of c	lying, such as	s cardiac o	r respiratory arr	rest,	gs,	Approximate
	Physician		Immediate Cause (Final disease or condition	of only one cause on e	Agreement	reutic	1504 1604	rer					Interval Between Onset and Death
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de	Examiner	.	Sequentially list conditions	b	Ken		ailur	5					
a.	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Least	Dus to	(or as a consequ	uence of):							
	icate be executed physician and the burial-transit	хаш	that initiated events resulting in death) Last	c	or as a consequ	ioneo of):							
38760,	be e) ician buria	a E		Due to	(or as a consequ	zence or,							
587	ficate phys s the	dical		d									
×	certif nding use a	₩.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	come pf pregna	ncy					23d Da	ate of delive	one
.O. Box	death e atte d for	Physician/Me	in the past 12 months?	4☐Pregr	oirth 2□Fetal nant at time of de		Ectopicpregnal Other <i>(sp</i> ec <i>ify)</i>					onth	Day Year
Ö	tt the by the	hys	9 Unknown	9∐Unkn	own								
Vital Records, P.	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	by P	Part II. Other significant condit	ions contributing to de	eath but not resu	ulting in the ur	derlying cause	given in Part I	l.	23e. Did to	bacco use con	tribute to t	he cause of death?
ord	equir en si ould h	ed	Hyper	ension						1 U Y	es 2 No	3 ☐ Prob	oably 4 □Unknown
ပို	law r as be 2 sh	Completed								24a. Was a		Were auto	ppsy findings available mpletion of cause of
<u> </u>	The ate h	Son								perfor	med?	death? 1 ☐ Yes	2 No
/ita	cian: ertific ector,	Be	25. Was case referred to medica examiner?						e of Death	(Check only on			
or.	Physi this c	2	1 Yes 2 No		·	ER/Outpatien	OLI DON		ursing Horr		ence 6 □Oth		у)
n C	ling F	ü	27. Manner of Death 1 Natural 5 □ Pendi		of Injury th, Day Year)	28b. Time of Injury	28c. In			8d. Describe he	ow injury occur	red	
S	ttenc death stor: / the	icat	3 Suicide 6 Could	not be	of injuny - At ho	mo form stre		□Yes 2□		Df. L anatis (O)			18.
Division or	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending, completely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 ☐ Homicide determ	nined buildi	of injury - At hong, etc. (Specify	()	et, lactory, offic	e	2	City or Town	n, State)	per or Hura	al Route Number,
	spita ours neral		29a. Certifier 1 Certifyi	ng Physician: To the	best of my know	wledge, death	occurred at the	time, date ar	nd place, a	nd due to the c	ause(s) and m	anner as s	tated
	ne Ho	edical	(Check only 2 Medica one)	Examiner: On the b	asis of examinat ner stated.	tion and/or inv	estigation, in m	y opinion, dea	ath occurre	ed at the time, d	late and place,	and due to	the cause(s)
	To the within comp.	Me	29b. Signature and title of certific				29c. Lice	nse number		2	9d. Date signe	d (Month,	Day, Year)
	,		M. 49a	him d	4 MY)	Do	005	290	19	4/3	0 3	007
	6		30. Name and address of persor	who completed caus	e of death (Item	23a) (Type, F	Print)						410 0.00 =
			ALI RAHIM		7501	SURF	CATTU	KOA	17 2	07 CI	-INTO	N	MD 20735
	Sta Registr		31. Date filed (Month, Day, Year 3 200	32. R	egistrar's Signat	good .	,						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav VIRGINIA Month 5 (((() 02 0220M 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 F 220-18-1144 82 Sept. 6, 1924 Maryland Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Arnold 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 341 Buena Vista Avenue USA 21012 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Keefer Stouffer Ethel Lee Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph H. Todd, III/Son 2157 Oakengate Lane Midlothian, VA 23113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 5, 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematroy Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Gueral Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 1/omes 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 2 No 1 ☐ Yes

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

"natural", or items

7 is marked other than "natur traumatic event, the Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

filed within 72 hours after death with the I Hygiene. «ther than "natural", or items 23a or 28a-

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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2

/Medical

10a. State

MD

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law requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

To the Hospital or Attending Physician:

Examiner Physician/Medical Completed by Be

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Certification:

Medical

physician attending p for use as ed by the a detached t signed b peen page 2 s certificate After this certific funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the

24a Was an 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

5 Pending investigation 6 Could not be determined

Hospital: 1 npatient 28a. Date of Injury (Month, Day Year) 28b. Time of

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work?

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

26. Place of Death (Check only one)

29b. Signature and title of certifie

0 3 2007

Name and address of person who completed cause of death (Item 23a) (Type

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

10

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Michelle Renee Taylor 2310 P M May 8. 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS- Memorial Campus Cumberland <u>Allegany</u> 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M Yrs. 310-72-5230 37 Jan 8, 1970 Indiana Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Allegany Cumberland 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 221 Baltimore Street Apt. 2 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZAMO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 💆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Lewis Steele, Sr. Patricia Kay Steele 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia K. Steele / mother P.O. Box 71, 2241 W Jefferson Kokomo, IN 46903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 5/10/2007 | Cumberland, MD 21502 21. Signatur of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 ulus 23a. Part1. Enter the disease, or complications that care shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ine. Approximate Interval Between Onset and Death Immediate Cause (Final Cirrhosin disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of alwh wronic Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) g Unknown 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

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an "natural", or items 23a or Medical Examiner must be

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Director

Funeral

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Completed

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Pages 1 and 2 should be filed in nent of Health and Mental Hygiint: If Item 27 is marked other

permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

Exami Physician/Medical

Completed

Be 2

Certification:

Medical

and the burial-trai attending physician as nse hed by the atter signed by be det has To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir

the death certificate be executed

The law requires that

Attending Physician:

Box 68760,

P.O.

Division or Vital Records,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
performed?	death?
1 Yes 2 No	1 ☐ Yes 2 No

25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)
1 Yes 2x No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined		et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
200 Cortifior 1 Cortifuing Di	welglan: To the best of my knowledge, death	occurred at the time, date and place	a and due to the square(s) and manner as stated

29a. Certifier (Check only one)	2 Medical Examiner: ○		e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
20h Cianaturo an	detitle of contifier	29c License number	20d Data signed (Month Day Vear)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Husam Semaan, M.D.,

09,200 D56207 900 Seton Drive, Cumberland, MD

MRS State Registrar

31. Date filed (Month, Day, Year) MAY 14 2007

man

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 2007 BEATRICE TOLLERIS APR 29 1:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. May 22, 1916 5. Social Security Number 9. Birthplece (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 90 Yrs. Director 089-09-9241 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Exeminar must be notified at 1 Yes 2 No Directo Chevy Chase Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Willard Avenue, Apt. # 820 20815 U. S. A. Pages 1 and 2 should be filed within 72 hours after death valued of the file Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23, ant. If Item 20 is the chart of the file was 1 is a file of the file was 1 in the file of th Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Time Inc. 5+ Promotional Writer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be May (Unascertainable) Isadore Klein 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5901 Mt. Eagle Drive, Alexandria, Virginia 22303 John A. Tolleris - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ang.e. 5/4/2007 Beth David Cemetery Elmont, L.I., New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction, Inc. Constal (4091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the grath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 s autopsy performed' 1 Yes 1 Yes 2 No 2 ₹ No To the Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending after death. investigation 1 Yes 2 No 2 Accident the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maliner as seen and due to the cause(s) and maliner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D40225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 MARK C. HAIGNEY MD egistrar's Signature MAY 0 4 31. Date filed (Month State 04 Registrar

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registral Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2007 RALPH TOLLERIS APR 29 2:25 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA 8. Date of Birth (Month, Day, Ye Mar. 19, 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1∏ M 2□ F Days Year) Months Hours Min Director 95 112-12-8579 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-fehow traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland | Chevy Chase Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ò U. S. A. 20815 4701 Willard Avenue, Apt. # 820 238 death 14. Race · American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. In Important: If Item 27 is marked other than "naturel", or Itel many injury or other traumatic event, the Medical Evanthea any injury or other traumatic event, the Medical Evanthea 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify þ 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Retail and Mail 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Order Boating Equipment Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Minnie (Unascertainable) Charles Tolleris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Mt. Eagle Drive, Alexandria, Virginia 22303 John A. Tolleris - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/4/2007 Elmont, L.I., New York Beth David Cemetery 22, Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licensee Donald Lerry 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** THALAMIC HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as attending j IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has autopsy performed? certificate 1 ☐ Yes 2 ₹ No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Xpatient Certification: To 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 XNatural 5 Pending after death. 1 Tes 2 No investigation the f 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ni bellii determined 4 Homicide within 24 hours after To the Funeral Dire ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medic To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40225 NATIONAL NAVAL MED CAL 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 MARK C. HAIGNEY MD 31. Date filed (Month, Day, Year) egistrar's Signature State 0 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30, 11:30 A M April 2007 Anna Louise Taylor /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fadlity Name (If not institution, give street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🔼 F 88 30, 1919 Pittsburgh, PA 206-12-7969 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 No Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 12805 Marlow Place U.S.A Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛭 No Specify: Specify: Black þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Domestic Housekeeping traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be James Austin ပ Myrtle May Patterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Bolinger / Daughter 12805 Marlow Pl., Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State d Mem. Park May 5, 2007 Lower Burrell, PA 22. Name and Address of Facility McGuire Funeral Service Inc. 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Mem. Park 21. Signature of Funeral Service Licensee hos 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 105 /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed MS and burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1☐ Yes 2XNo 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9∏Unknown 9 ☐ Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed Physician; 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 26 No 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 ☐ Pending investigation n 24 hours after death.
ne Funeral Director; A
pletely filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier To th. within 24. 29c. License number 29d. Date signed (Mogth, Day, Year) 29b. Signature and title of certifier

3altimore,

P.O. Box 68760,

Vital Records,

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Division

State

31. Date filed (Month, Day, Year) MAY 04 Registrar

_Name and

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL **Physician** EDWARD 2007 D. TALBERT. III 30 12:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 11X M 2 □ F 60 579-62-2465 April 25,1947 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 □ Yes 2 TVNo Director MDDamascus Montgomery 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20872 25316 Clearwater Drive United States Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 212 No Specify. δ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metropolitan Police Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Edward Downer Talbert, Jr. Elizabeth Houghton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce T. Eastman/Daughter 25316 Clearwater Drive, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5/3/2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demen fis Due to (or as a consequence of): coho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident

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Funeral

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Items 23a or 2 Iner must be n

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permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

that the death certificate be executed Hospital or Attending

Division or Vital Records,

State Registrar 30. Name and ad for of perion who completed cause of death (Item 23a) (Type, Print) HEKRY 4 TSAY,

MAY

29b. Signature and title of certification

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier (Check only one)

4 Thomicide

6 ☐ Could not be determined

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2007

400 West 7th Street, Frederick, Maryland 21701

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			1 - For State Registrer	State of Maryla	nd / Depa	artment	of Health and I	Mental Hyg	jiene leg. No.	0.7	1630	9
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Marlene G. 4a. Facility Name (If not institution, give state)	street and number)	Vence-C	4b. City, To	wn, or Location of Death	2. Date of Dea Month May	2, Day 20	O7 Nty of Death	3. Time of De. 7:40A.	ath M
	Funeral Director		11101 Montgomery 5. Social Security Number 147-34-6921 Usual Residence of Decedent		. last birthday) Yrs.	If Under 1	tsville Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day AUG • 13		9. Birthr	orge's place (State or Fo	reign
	he Maryland Ba-f show officed at	ector	10a. State 10b. County Maryland Prince Ge	_	ity, Town or Lo	le					10d. Inside City L 1 ☐ Yes 27	
	th with the 23a or 2	al Dir	11101 Montgomery Ro	oad		10f. Zip C	705	1	Og. Citizen o Unite		•	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinational Secretifical at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates:			nt of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)		ace - Americ lack, White, hify:		
1215-0	filed within 72 hc Hygiene. other than "natur ent, <u>tre Medical</u>	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give		Occupation done during most of wor retired) Ssistant	king	16b. Kind of	Business/In	dustry	
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	Tand 2 sh Health and Iem 27 is m		19a. Informant's Name/Relationship (Ty) Joseph F. Cramptor				street and Number or Ru gomery Road		. ,		,)
Baltimore,	permit. Pages 1 a Department of He Important: If Item any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Me	-	itan C	cematory 5/	3/2007		dria,	Virgini	
Balt	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Linense	Mundo	DX 44	ona186 400 Po	W. Borgward wder Mill R	t Funera oad Belt	l Home sville	, PA Mar	vland 20)70
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_			30. Name and address of person who co Fitzgerald Birming 31. Date filed (Month, Day, Year)	npleted cause of death (Itel) ham, M.D. 10	6 Irvin	g St.,	N.W.,#4200	(N.Tower)) Washi	ingtor	n,DC 200	10
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	Funeral Director		5. Social Security Number 220–05–9104	6. Sex 1 □ I	M 2 X F	7. Age (In yrs	5. last birthday) 5. Yrs.	If Under Months		nder 24 Hrs. urs Min.	8. Date of (Month AUG.	Day Y	1921		ace (State or Foreign try) YLAND
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6			30. Name and address of co.	rson who com	pleted cau	se of death (Ite	om 23a) (Type, I	Print) 15 L	NOVE.	F115	ton,	17	D 12	1601	
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	Physicia	20	1. Decedent's Name (First, Middle, Last)						2	2. Date of Deat		Year	3. Time of Death
п	Physicia /Medic		Alice R. York							April		2007	2:00 p ^M
	Examin	er	4a. Facility Name (If not institution, give street a	nd number)		4b. City,		Location of asade				nty of Death IE Aru	
			115 Litton Dale Lane 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	ndavi	If Under		If Under 2		B. Date of Birth			
н	Funeral Director		002–16–6439 1□ M 2₹	5-	rs.	Months	Days	Hours	Min	Month, Day, Teb. 16	, 1921	Cou	place (State or Foreign intry) [alne
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	with t	ă	10e. Street and Number			10f. Zip		21122		1	0g. Citizen o	What Cou USA	-
	eath	eral	115 Litton Dale Lane 11. Marital Status 12. Was	Decedent Ever in U.S.	13. V	Vas Deced				ifv Yes or No-	14. R	ace - Amer	
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5-0036	ral', o	þ	3 ☑ Widowed 4 ☐ Divorced Yea	es, Give r or Dates:	1	Yes	2 X No	Specify:			Spec	cify:	
2	filed within 72 hours after death with the Maryland Hygiene. Hygiene. That "hat was natural", or items 23s or 28e-f ehow ant, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp.	16a. (Deced (Give	lent's Usua kind of wo	al Occupa rk done d	ation during most	of working	9	16b. Kind of	Business/Ir	ndustry
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i D	Hygie Hygie thert nt, th	ပိ	17. Father's Name (First, Middle, Last)			Hom	emak		r's Name /	First, Middle, I			
and	d be d	То Ве	Napoleon Paul						rise				
Maryland	shoul nd Man	Ĕ	19a. Informant's Name/Relationship (Type, Prin	t) 19b.	Mailin	g Address	(Street a	and Numbe	r or Rural	Route Number	, City or Tow	m, State, Zi	ip Code)
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altimore,	of He of He fiter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal		, cren	natory or o	ther plac	θ) []	May 2	te	20c. Location		
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Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene *natural', or iteme 23a or 28e-f ehow eny injury or other treumatic event, the Medical Examinal mant is notified at once.		21. Signatur Fureral Service Licensee	M	Ba 49	Name and PS GO	d Address CO & V. R	Sons itchi	P.A. e Hwy	A. Seve			uneral Home MD 21146
			23a. Part. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do no	ot ent	er the mod	le of dying	g, such as	cardiac or	respiratory arri	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	metartar	Ti	1	an	u					Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence o	1):			lon					
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	nsit	nine	cause. Enter Underlying Cause (Disease or injury	20 10 (01 23 2 0011304 1100 0	.,.		6						
<u> </u>	s be executed sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last	ue to (or as a consequence o	f):								
760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	cai	d.										
89	h certifica anding ph use as th		IF FEMALE:										
Вох	eath certif attending for use a	lan/I	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy Live birth 2 Fetal death		Ectopic pr						Date of deliv	very Day Year
o.	at the de by the a tached f	Physician/Med	1 Vas 2 HMA	Pregnant at time of death Unknown	5	Other (sp	ecify)						
۳.	res that ti igned by be detac		Part II. Other significant conditions contribution	g to death but not resulting in	the ur	nderlying c	ause give	en in Part I.		23e. Did tot	pacco use co	ontribute to	the cause of death?
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ta	icien: Th certificete rector, pag	BeC	25. Was case referred to medical					26. Place	of Death ((Check only on		- 10,103	20110
>	S 52 D	To	examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/Out	patien	t 3 🗆 DC	Othe Othe	er: 4 🗆 Nu	rsing Hom	e 5 Reside	ence 6 🗆 C	Other (Spec	ify)
Ē	Attending Physicien: ar death. Sctor: After this certifice by the funeral director.		T Chataia C Citoling	Date of Injury 28b. Ti (Month, Day Year) In	me of		28c. Injury Work			3d. Describe ho	ow injury occ	urred	
<u>s</u>	death death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	Disco of laive. At home for		M		Yes 2 1		of Location (St	troot and Nu	mber or Pur	ral Route Number,
\leq		Certification:	4 Homicide determined	Place of Injury - At home, fari building, etc. (Specify)	III, SU	eet, ractory	y, onice		20	City or Town		mber or Nai	ar noble resilber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	(Check only 2 Medical Examiner: On	To the best of my knowledge, the basis of examination and manner stated.	Vor inv	estigation/	, in my op	oinion, deal	th occurred	d at the time, d	ate and place	e, and due	to the cause(s)
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier			290	c. License	number		2	9d. Date sign	ned (Month	Day, Year)
			· Curtis Ha	En.		_	1)	533	06		4/3,	0/0	מל
	106	12	30. Name and address of person who complete	cause of death (Item 23a) (I	Туре,	Print)	30%	e R	d c	xe 300	o As	1 runs	olis MO
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2007	d cause of death (Item 23a) (Implementation of the complementation o	Sou	who						- 1.0	

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at Baltimore, Maryland 21215-0036 YEAT MAN VIRGID IA

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physician ard s the burial-trans law requires that the death certificate be execute attending ph ed by the a signed by I be deta certificate has b irector, page 2 sl funeral director After this

Box 68760

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Division or Vital Records,

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician 1316 VIRGINIA G. YEATMAN APRIL IS 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITUL Easton TALBOT MEMORIAL If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ X 81 MARYLAND 220-22-8659 OCT 23, Director 1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director TALBOT EASTON MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 610 DUTCHMANS LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VIOLA JONES MILTON L. GREENWOOD ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29402 HOWELL POINT RD., TRAPPE, MD 21673 PAUL E. MOORE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WHITEMARSH CEMETERY 5/2/2007 TRAPPE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 S. HARRISON ST., EASTON, MD 21601 Ostrowski C.FS.P Lioseph m. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mocardia Due to (r as a consequence of): 0104 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 100 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 225/100 1 Impatient 1 TYes 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST., EASTON, MD 21601 DENNIS M. DESHIELDS M.D. 32. Pygistrar's Signature 31. Date filed (Month, Day, Year) State APR 3 0 Registrar

Daron Blackwell		Please Type or Print in Black Indelible Ink. Ensure All Copie		ible.	
Darbh Blackweil		State of Maryland / Department of Health and Mental H	iygiene	2007	16311
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Medical Examin	-	Baron Charles Blackwell	Month 1 May 14, 200	Day Year	1520 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatt	h	4c. County of Death	
		1701 Eutaw Place Apartment 914 Baltimore			
juneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr.		(MM/DD/YYYY) 9. Birti	
Director	ļ	218-48-800 120 M 2 F 6 Yrs. Months Days Hours Mir	12/13	1945 Foreign	ntry) MD
	Ì	Usual Residence of Decedent	11017101		-11.02
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
and f sho	٥	MD Baltimore			1 Yes 2 No
Mary 28a-	Director	10e. Street and Number	10g	. Citizen of What Coun	try?
r death with the Maryland or items 23a or 28a-f show must be notified at once.		1701 Eutaw Place, Suite 914 21217		<u> USA</u>	
th wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
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MD and 2 sho salth and 2 sem 27 is	-	Van-Lear Blackwell (Brother) 1535 N. Bentalou S 20a. Method of Disposition (Name of cemetery,		mre, md	Olollo Inwn State
altimore, rmit. Pages 1 ar epartment of He pportant: If ite		1 2 XXCremation 3 Removal from State crematory or other place)	1 +		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Synalure of Juneral Service Licenses 22. Name and Address of Facility (Charles)	ices	Lan money	21229
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Examiner	- 1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
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Box 68760, re death certificate but the attending physic red for use as the but	<u> </u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy		ay Year
x 6 tth cer tttendi	흲	4 Pregnant at time of 5 Other (Specify)		_	
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F.O. ires that the signed by (É	Terminal renal disease		2 No 3 Proba	
duires	ted	Tominar Total dioddo	24a. Was an		opsy findings available
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Division of Vital Records, tal or Attending Physician: The law requirens after death. "al Director: After this certificate has been simply the funeral director, page 2 should be in by the funeral director, page 2 should	BB	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing 1 Nursing 1 Nursing 1 Nursing 2 N		esidence 6 🗸 Other:	Conn
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isic	ical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		eet and Number or Run	al Route Number, City
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
47-3-0	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	h, Day, Year)
9		O.C.M.E.	İ	May 15, 2007	
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	 1		36
Sta	ate.	all a			
Registi		31. Date filed (Month, Day, Year) MAY 2 1 2007 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #20b, perFH, G867, 5/21/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 647 AM imle 2007 /Medical 4b. City, Town, or Location of Death acility Name (If no institution, give street and our 4c. County of Death Examiner ood Samaritan Baltimore HOSDITA 8. Date of Birth (Month, Day, If Under 24 Hrs. Hours Min. Social Security Number 6. Sex (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months Days 1**X**M 2□ F 430-70-0638 Director Arkansas Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Baltimore 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e 21206 ISA r than "natural", or items 23a the Medical Examiner must t Funeral 12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes 2☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) DWner es 1 and 2 should be filed vor Health and Mental Hygie of Health and Mental Hygie fitem 27 is marked other to other traumatic event, the Name (First, Middle, La 17. Father 18. Mother's Name (First, Middle, Maiden Surname) Be BriMley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brimle Brother rm Au Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☐ Cremation injury or 3 | Removal from State Department o Important: If any injury or 5 ☐ Other (Specify) 4 □Donation 21. Signature of Funeral Service Licensee Pd. Ba 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VENTAICULAR **Physician** KAILUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner MONARY DUSEASE TEN YEAR for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown þ Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes page 2 should The law 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate 1∐ Yes 2 No or Vital 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Ves 2 No 27. Manner of Death Hospital: Other: 4 Nursing Home 1 Inpatient 2 TER/Outpatient 3 DOA Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 34041 completed cause of death (Item 23a) (Type, Print) and address of person who 3 5601 LOUIT RAVENBLUZ BALTIMONS MD 21239 ELLE

DHMH 17 Rev 1/2001

State Registrar Day, Year)

32. Registrar's Signature

07-03502 Melvin Burroughs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

CIVILI Barroagi		1-For State Registrar Grant For State Certificate of Death	rgiene Reg	. No. 201	7 1631						
Physici			2. Date of Death		3. Time of Death						
ledical Exami	ner	Melvin Burroughs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month May 7, 2007	4c. County of Dea	0935 hrs						
		123 West 29th Street #10J Baltimore		10. County of Bea							
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth	(MM/DD/YYYY) g. B Fore C							
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D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma	aiden Surname)	unk						
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Box 687 death certific the attending p	Physician/	2 Petal death Sectopic pregnal at time	nicy	Month	Day Year						
, P.O. Box 687 res that the death certifi signed by the attending be detached for use as t	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?						
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ion (tending eath.	tion	Natural 5 Pending 1 Yes 2 No		• •							
Division of Vital bital or Attending Physician: urs after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St or Town, Sta		Rural Route Number, City						
Division of Vital Records, P.O. Box 68760, within 24 blooks after the death certificate be executed within 24 blooks after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.									
F % F 8	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)						
		Theoder M. H. J. Try, mrs. O.C.M.E.		May 8, 2007							
_		30/Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e. MD 21201								
S	tate	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	-, 1201								
Regis	trar	MAY 2 1 2007 Glown & freelis									

DHMH 17 Rev 1/2001 OCME 2006

07-03569 Dennis Burke Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nnis burke		1	l-For State Registrar	of Maryland / I		rtment of tificate of		na ivie	ntal Hy	_	eg. No. 2	00	7 1631
Physical Exa		n/	Decedent's Name (First, Middle,Last)							2. Date of Dea Month May 9, 20	Dav Ye	ar	3. Time of Death 0945 hrs
			Dennis Burke 4a. Facility Name (if not institution, give	street and number)		4	b. City, Town,	or Locatio	n of Death	May 9, 20	4c. County	of Death	
-			Good Samaritan Hospital	7 400/	la ura la	at hirthday)	Baltimore		der 24Hrs.	9 Date of Riv	th (AAA 4/DD 0000	A O Die	hplace (State or unk
Funera Directo			5. Social Security Number $\displaystyle rac{1}{2}$	M 2 F	42	st birthday) Yrs.		ays Hou			, 1965	Foreig	ntry)
m		-	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City,	Town or Location	on						10d. Inside City Limits
nd show s	9	۱	MD			Baltim	ore						1 X Yes 2 No
Maryla 28a-f	d at or	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of W	hat Coun	try?
ith the	notifie		3804 Biddison Lan			140.00	Developed	2120				SA	District District
eath wi	nst pe	Funeral	11. Marital Status unk 1 Never Married 2 Married	12. Was Decedent Ex Armed Forces?	7	S. 13. Was	s Decedent of es, specify Cul			ecify Yes or No Rican, etc.)		e - Americ e, etc.	can Indian, Black,
after d	mer m			1 Yes 2 If Yes, Give Year or Dates:	No	The state of the s	Yes 2 X				Specify:		lack
2 hours	Exam	Completed by	15. Decedent's Education (Specify onl	y highest grade compl College (1-4 or 5+	_	16a. Decedent during mo	's Usual Occu st of working	pation (Giv ife. DO NO	ve kind of w OT use retir	vork done ${f un}$ red)	16b. Kind of B	usiness/li	ndustry unk
036 ithin 7.	Tedica	餇		ınk									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bearunent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any	t, the	اق	17. Father's Name (First, Middle, Last)				unk	18.Moth	er's Name	(First, Middle,	Maiden Surnam	e)	unk
212 ould be I Ments	ic even		19a. Informant's Name/Relationship (Ty	pe, Print)	-	19b. Mailing	Address (St	reet and N	umber or F	Rural Route Nur	mber, City or Tox	vn, State,	Zip Code)
MD nd 2 sho alth and m 27 is	aumat		O.C.M.E.		1 ani 1				Ba1t	imore,			
Baltimore, permit. Pages I an Department of Hea Important: If iter	ther to		20a. Method of Disposition 1 Burial 2 Cremation 3			lace of Disposi rematory or oth		cemetery,		Date	20c. Location	- City or	rown, State
altim nit. Pa artmen	13 Or	ł	4 Donation 5 X Other Specify: 21. Signatur of Juneral Service Licens	in state		22. _N	ame and Addr	ess of Fac	ility	J 655 11	. Balti		04
B Per JE.	Ē	i	1 samal	11 THE	1	l Bai	ltimore	. MD	212	01			Street
Physicia /Medica			23a. Part i. Enter the disease, or compli failule. List only one cause on each	h line.		Do not enter th	e mode of dyi	ng, such as	cardiac o	r respiratory arr	est, shock, or he	eart	Approximate Interval Between Onset and Death
Examine	er			Hemopericardium):						_	Deau
	ı	_	Sequentially list conditions,	Ruptured Aortic D									
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. Hypertensive Cardiovascular Disease										
uted	ransit		other cooling in sealing last										
), be exec	urial - t	Medical	UNPENDED AMENDED										
876C	is the bi		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month								,	ay Year
Box 68760, e death certificate be executed the attending physician and	or use	Physician/	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at tir	ne of dea	44	ner (Specify)		F F 5		4		-,
O. B. trhe de	ached t			9 Unknown contributing to death b	out not re	sulting in the u	nderlying caus	e given in	Part I.	23e. Did t	obacco use con	ribute to	the cause of death?
s, P.O. Baires that the de	d be det	d by								1Ye	s 2 No 3	✓ Prob	ably 4 Unknown
Vital Records ysician: The law requirents certificate has been a	shoul	Completed								24a. Was autor	osy	prior to c	topsy findings available ompletion of cause of
Rec The la	, page	틩								1 ✔ Yes	rmed? 2 No	death? I ✔ Ye	s 2 No
Vital hysicians this certi	lirector	o Be	25. Was case referred to medical examiner?	ospital: 1 / Inpatient	2	ER/Outpatient		Other	th (Check of Nursin	only one) ig Home 5	Residence 6	Other	
of \ ing Phy After th	neral	⊢	27. Manner of Death	28a. Date of Injury (Month, Day, Yea		28b. Time of Ir		njury at W			how injury occu		
Sion Attendi death	y the t	턣	1 Natural 5 Pending 2 Accident Investigation	n	4			Yes 2					
Division /	illed in	Certification:	3 Suicide 6 Could not b determined	e 28e. Place of Injur (Specify)	y - At ho	me, farm, stree	t, factory, offic	e building,	etc.	or Town, S		er or Ru	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Physicia on 2 Medical Examiner:	n: To the best of my k On the basis of exami and manner stated.	_				-				
F B F	ŏ	B	29b. Signature and title of certifier) , ,)				ense numb	er				nth, Day, Year)
			(alert	elle			0.	D.M.E.			May 10, 2	007 ———	
			 Name and address of person who c Laron Locke MD. Assista 	ompleted cause of dea ant Medical Exan			Street, Ba	timore,	MD 212	01			
Reg	Sta	ite ar	31. Date filed (Month, Day, Year) WAY 2 1 200	3 Registrar's	Signatur	e losa							

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 11, 2007 **Physician** 4:15 Pm M Ruth Dillon Brock /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Cockeysville Broadmead If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Aug 29, 1923 9. Birthplece (State or Foreign Country)
Georgia 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 🛛 F 83 254-32-7971 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits Item 27 ie marked other then "natural", or Itama 23a or 28a-f ehow other traumatic event, the Modical Examinet must be notified at 1 ☐ Yes 2 ☑ No Director M Baltimore Cockeysville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 13801 York Road G3 21030 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Thompson Dillon Ruth Cochran permit. Pages 1 and 2 sh.
Department of Health and A
Important: If Item 27 i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Brock/daughter 20 Andrews Avenue Falmouth, ME 04105 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ፟ ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Romald S. Wadte State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ens Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ed bluods 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 2 []/No ne hosp... in 24 hours after deam. the Funeral Director: After this certifica.v "...≺ in by the funeral director, p? Vital Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No To Be 26. Place of Death (Check only one) Hospital: Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA to 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation or Attending 1 3 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

07-03435 Hert Ме

03435 bert L. Beall		Please		or Print in Bl							ible.		
bert E. Bean		1- For State Registrar	State	of Maryland		ificate of		na mentar	пуді		. No.	200	7 1631
Physicia dical Exami		1. Decedent's Name (Fir Herbert L		,					- 1 1	Date of Death Month May 5, 200	Day 7	Year	3. Time of Death 0938 hrs
		4a. Facility Name (if not 5805 42nd Ave		ve street and number)			4b. City, Town, Hyattsville	or Location of De	eath			ounty of Death Ce George	
Funeral Director		5. Social Security Number	~	Sex 7. Age	e (In yrs. las	st birthday)				Date of Birth		Eoroia	thplace (State orunk gn untry)
any		Usual Residence of Dec 10a. State 10b.	edent County		10c. City, T	own or Locat	ion						10d. Inside City Limits
. .	ctor	MD P		George's	Ну	attsvi	11e			100	. Citizen	of What Cou	1 Yes 2 X No
h the Ma 3a or 28 lotified a	Director	5805 42nd		#409		•	<u></u>	20781			,, , , , , , , , , , , , , , , , , , , ,	USA	,.
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ns after ural", o	<u>ج</u>	3 Widowed 4		d If Yes, Give Year or Dates:	pleted)	1 1 16a. Deceder	Yes 2 X I	No specify:	of work	dometrik I	<u> </u>	ecify: wh	
6 n 72 hou ian "nat	oletec	Elementary/Secondar	y (0-12)	College (1-4 or				ife. DO NOT use					
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she r event, the Medical Examiner must be notified at once	e Completed	unk 17. Father's Name (First		unk t)			unk	18.Mother's N	ame (Fi	rst, Middle, M	aiden Sur	rname)	unk
2 5 D S E	To Be	19a. Informant's Name/F	Relationship (Type, Print)			•	eet and Number					e, Zip Code)
e, MD 2 I and 2 shou Health and M item 27 is n		O.C.M.E. 20a. Method of Dispositi				ace of Dispos	sition (Name of	reet Bal		ore, M		1201 ation - City or	Town, State
> 8 5 = 5		1 Burial 2 C 4 Donation 5 X	Other Specif	y in state	e	ematory or ot							
Baltimo		21. Signature of Funeral Rona	Service Lice	Wade, Dire	ctor	Sta Bal	Name and Addr ate Anat Ltimore,	ess of Facility Comy Boa MD 21	rd 6 201	555 W.	Ba1t	imore	Street
Physician /Medical		23a. Part I. Enter the dis failure. List only or	ne cause on e	each line.									Approximate Interval Between Onset and Death
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	iner	Sequentially list condition if any, leading to immed cause. Enter Underlying	iate	Due to (or as a conse	equence of)								
ed	Examiner	(Disease or injury that in events resulting in death	nitiated	Due to (or as a conse	equence of)	:							
fox 68760, leath certificate be executed e attending physician and for use as the burial - transit	ca	X UNPENDED		#23a,27,28	a-f. ne	erME. 28	67. 5/22/	′07 TT					
8760 tificate t ng physi as the bu	sician/Medi	IF FEMALE: 23b. Was decedent preg past 12 months?	nant in the	23c. If yes, outcor		ancy		3 Ectopic pre	egnancy	,		ate of deliver	y Day Year
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P.O. Es that the d	by Phy	Part II. Other significan	nt conditions	contributing to deat	h but not res	sulting in the	underlying caus	e given in Part I.					the cause of death?
ords, P.C. w requires that as been signed to should be deta	Completed									24a. Was a	n	24b. Were a	utopsy findings available completion of cause of
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ision of Vital Rec Attending Physician: The r death. ector: After this certificate by the funeral director, page	o Be	25. Was case referred to examiner? 1 Yes 2	nedical No	Hospital: 1 Inpatie	ent 2	ER/Outpatien		Other N			Residence	e 6 🗸 Othe	er: Scene
n of \ding Phy	_	27. Manner of Death		28a. Date of Inju (Month, Day,)	iry 'ear)	28b. Time of		njury at Work?		d. Describe h		occurred	
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Divis To the Hospital or / within 24 hours after To the Funeral Dire		4 Homicide	determin	ed (Specify) re	esidenc								Hyattsville,
To the H within 24 To the Fi completel	Medical	(Check only		cian: To the best of m er:On the basis of exa and manner stated.									
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		30. Name and address of					ot Baltima-	- MD 21201					
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OLIF COOC													

07-03542 Robert Baldwin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 16320

		For State	Certificate of	f Death		Reg.	No.	
Physicia		Decedent's Name (First, Middle,Last)				2. Date of Death Month	ay Year	3. Time of Death 1245 hrs
1 Examin	er	Robert Baldwin				May 8, 2007		
	4	a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of D Harford	reaut
		516 Eastern Court		Aberdeen	If Under 24Hrs	8. Date of Birth		Birthplace (State orunk
Funeral	5	, , , , , , , , , , , , , , , , , , , ,	(In yrs. last birthday)	If Under 1 Year Months Days		1	F	oreign Country)
Director		1XM 2 F	70 Yr	s.		Sept 28	, 1936	Country)
3.		Isual Residence of Decedent	10c. City, Town or Loca	ation				10d. Inside City Limits
w any	1	ou. state	Aberde					1 Yes 2 X No
Maryland 28a-f show d at ouce.	١ق		Aberded	10f. Zip Code		100	. Citizen of What	Country?
Mary 28a- ed at	Director	Oe. Street and Number 516 Eastern Court		210	01		USA	
with the Maryland ms 23a or 28a-f sbo be notified at ouce.			Ever in U.SUN K 13. W	(as Decedent of His	nanic Origin? (Si	necify Yes or No-	14. Race - /	American Indian, Black,
ath wit items 2	76 I	1. Marital Status UNK 12. Was Decedent Armed Forces?	ever in o.sum kis. w	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	White, e	etc.
or it	ᇍ	1 Yes 2	No 1	Yes 2 X No	specify:		Specify:	white
s afte	출 -	Widowed 4 Divorced of Paragraphics Size Year or Dates: 15. Decedent's Education (Specify only highest grade com	pleted) 16a. Decede	ent's Usual Occupa	tion (Give kind of	work done unk	16b. Kind of Busin	ness/Industry unk
hour "natu	eted	Elementary/Secondary (0-12) College (1-4 or 5	during	most of working life	, DO NOT use ret	ired)		
136 thin 72 ne. than edical	릛	unk unk						
d with	Comple	17. Father's Name (First, Middle, Last)		unk	18.Mother's Name	e (First, Middle, M	aiden Surname)	unk
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", re event, the Medical Examiner	Be (
Jre, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-fahr her traumatie event, the Medical Examiner must be notified at ouce	庐	19a. Informant's Name/Relationship (Type, Print)		ing Address (Stre				_
		O.C.M.E.		l Penn St		Date Date		City or Town, State
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Pages ent of	- 1	4 Donation 5 X Other Specify: in state						
Baltimore, permit. Pages I at Department of He Important: If ite	ı	21 Signature of Funeral Service Licenses	ector St	Name and Addres	s of Facility omv Boar	d 655 W.	Baltimo	re Street
0	ı	INDON' / INSHIE	B.	altimore,	MD 212	01	et shock or hear	t Approximate Interval
hysician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.			i, sucii as cardiac	or respiratory and	ori oriooni or rioon	Between Onset and Death
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		or condition resulting in death) Due to (or as a cons	equence of):					
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	equence of):					
	Examiner	cause. Enter Underlying Cause						
d sit	Xai	events resulting in death) Last Due to (or as a cons	equence of):					
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O, be est siciar	Medical	3/112/323	me of programmy				23d. Date of	delivery
3760, ficate be g physici s the burn		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outco		Fetal death 3	Ectopic preg	nancy	Month	Day Year
Box 687 e death certific the attending	sician	past 12 months?	Ulara of death	Other (Specify)				
Boy e deatl the att	Phys	1 Yes 2 No 9 Unknown g Unknown			i Deal	220 Did to	hacco use contrib	oute to the cause of death?
P.O. es that the igned by 'be detach	by P	Part II. Other significant conditions contributing to dea	h but not resulting in th	ne underlying cause	e given in Part I.			✓ Probably 4 Unknown
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							sy p	rior to completion of cause of eath?
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ecords he law requi	omplet					perfo		✓ Yes 2 No
Il Records, P.O. Box 68. In: The law requires that the death certificate has been signed by the attending tor, page 2 should be detached for use as:	e Completed	25. Was case referred to medical		26.Pla	ce of Death (Chec	perfo 1 Yes	2 No 1	
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f Vital Physician: er this certifi	To Be C	examiner? 1 Ves 2 No Hospital: 1 Inpat 27. Manner of Death 28a. Date of In (Month, Day		of Injury 28c. Ir	Other Nur	perfo 1 Yes k only one) sing Home 5	2 No 1	Other: Scene
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Division of Vital I Hospital or Attending Physician: 24 hours after death. Pemeral Director: After this certif	Certification: To Be C	examiner? 1 Yes 2 No Hospital: 1 Inpat 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	very knowledge, death o	ient 3 DOA of Injury 28c. Ir 1 street, factory, office	Other Nur Nur Nur Nur Yes 2 No e building, etc.	performance of the performance o	Residence 6 whow injury occurrence and Number Street and Number State)	Other: Scene ed er or Rural Route Number, City as stated.
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ORIGINAL

Ernest J. Buchanan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 16321

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certi	ficate of	Death			Reg. N	0.		
Physici	G 1 U	Decedent's Name (First, Middle,Last)					2. Date Mon	of Death th Day	/ Year	3.	Time of Death
al Exami	iner	Ernest J. Buchanan					Apri	1 26, 2007			1117 hrs
		4a. Facility Name (if not institution, give street as University Hospital	nd number)	41	b. City, Town, or Baltimore	Location of De	ath	ľ	4c. County of I	Death	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	hirthday)	If Under 1 Yea	ır İf Under 24I	Hrs 18 Da	te of Birth (M	M/DD/YYYY)	Rirthn	ace (State or
Director				,,	Months Day		∕lin.		F	oreign	
		213-23-7714 1X M 2 Usual Residence of Decedent	F 1	8 Yrs.			De	c 18,	1988	Count	Maryland
any		10a. State 10b. County	10c. City, To	own or Location	on					10	d. Inside City Limits
A . t	_	MD Baltimore	R	eister	stown					1	Yes 2 X No
faryland 28a-f show	cto	10e. Street and Number		1	10f. Zip Code			10g. C	itizen of What		
ith the Maryland 23a or 28a-f sho notified at once.	Director	438 Main Street			•	21126					
with t s 23a e not			Decedent Ever in U.S.	13. Was	Decedent of His	21136	Specify Ye	es or No-	14. Race - /		Indian, Black,
leath r item	Funeral	1 X Never Married 2 Married Arm	ed Forces? /es 2 X No		s, specify Cubar				White, e	etc.	
ufter of	by Fi	3 Widowed 4 Divorced If Yes, Giver or Dates:		1	Yes 2 X No	specify:			Specify:	whi	te
ours a atura		15. Decedent's Education (Specify only highes	t grade completed) 1		s Usual Occupa			ne 16b	. Kind of Busir		
6 172 h an "n cal E:	ompleted		ge (1-4 or 5+)	auring mo	ring most of working life. DO NOT use retired)						
5-0036 led within 72 tygiene. other than "	m	11	0	s	alesper				ight f	ixtu	res
filed Hyg	ပိ	17. Father's Name (First, Middle, Last)				18.Mother's Na			,		
21215-0036 suld be filed within 7 Mental Hygiene. marked other thau c event, the Medira	o Be	Ernest Buchanan Sr 19a. Informant's Name/Relationship (Type, Print	,	10h Mailine	Address (Stree			metzer		0	
○ 등 절 :	ř	Ernest Buchanan Sr/fa		_	•				,		,
ore, MC es 1 and 2 s of Health au If item 27		20a. Method of Disposition			S. Bethe		Date		c. Location - C		
E E E		1 Burial 2 X Cremation 3 Remo	val from State cre	matory or oth	er place)			_		•	
timen rtmen rtant		4 Ponation to X Other Opening. 111		sapekae (Crematory	5	/29/20	07 Be	eltsville	e, MD	0717
Baltimo permit. Page Department of Important; injury or ott		21. Signature of Funeral Service Licensee, Director 22. Name and Address of Facility Cremation & Funeral Alto State Anatomy Board 655 W. Baltim Baltimore, MD 21201 Green Pastures D.									Street
ıysician	_	23a. Part I. Enter the disease, or complications i	hat caused the death. D	o not enter the	e mode of dying.	such as cardia	ic or respira	reen Pas atory arrest, s	hock, or heart	r. 10	Approximate Interval
/Medical		failure. List only one cause on each line.	ounds of the Tors								Between Onset and Death
Examiner			as a consequence of):	o and Ann							
		Sequentially list conditions, b									
	Examiner	if any, leading to immediate Due to (or cause. Enter Underlying Cause	as a consequence of):								
	tam	(Disease or injury that initiated C.	as a consequence of):								
cuted nd transi		d									
760, ficate be executed g physician and s the burial - transit	//Medical	UNPENDED X AMEN	X 4 202 - ,22, per FH, C867, 5/31/07 TT								
760, ficate be g physici the buri	Me.	IF FEMALE: 23c. If	yes, outcome of pregna	ncy				- 1	23d. Date of de	elivery	
	sician	past 12 months?	live birth Pregnant at time of death		al death 3	Ectopic pre	gnancy		Month	Day	Year
Box 68 e death certil the attending	ysic	1 Vos 2 No 0 Hakagua	Jnknown	5 Oth	er (Specify)						
P.O. Box 68: that the death certifi ned by the attending detached for use as if	Phy	Part II. Other significant conditions contribut	ing to death but not resu	ulting in the ur	nderlying cause	given in Part I.	23	e. Did tobaco	co use contribu	ite to the	cause of death?
, P.O ires that to signed by	b						1	Yes 2	✓ No 3	Probab	ly 4 Unknown
ords, w requir s been s should [Completed		•				24	a. Was an			sy findings available
e law e has e bas	E E						- _	autopsy performed	? dea	ath?	pletion of cause of
F Re		25. Was case referred to medical			26 Place	e of Death (Che		Yes 2	No 1	Yes	2 No
Vital Rec ysician: The his certificate	B	examiner? Hospital:	✓ Inpatient 2 El	R/Outpatient		Othor:	rsing Home		dence 6	Other:	
1 of Vital Records, ling Physician: The law requiri After this certificate has been si funeral director, page 2 should b	<u>۲</u>	27. Manner of Death 28a.	Date of Injury 2	8b. Time of In		ry at Work?			njury occurred		
ion tendin eath tor: A	tion	- rending	Month Day Year) 26, 2007	045 hrs	1	Yes 2 🗸 No	Subje	ct stabbe	d		
Division tal or Attendii rs after death al Director; A	fica	2 Accident Investigation 3 Suicide 6 Could not be	Place of Injury - At hom	e, farm, street	t, factory, office I	building, etc.				or Rural	Route Number, City
Div spital o	Certification:		ecify) Restaurant				31 Sou	Town, State) uth Calvert	Street, Baltin	nore, M	d.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as											
To the Hos within 24 h To the Firm	Zead. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Suphature and title of certifier 29c. License number 29d. Date signed (Mon									to the c	ause(s)
	ž	29b. Signature and title of certifier	\wedge		29c. Licens	se number		29	d. Date signed	(Month	Day, Year)
	(affirtubeno	J		O.C.	M.E.		A	oril 27, 200	7	
		30. Name and address of person who completed cause of death (Item 23a)									
					Street, Baltii	more, MD 2	1201				
Si Regis			2 Registrar's Signature	Aces	20						

DHMH 17 Rev 1/2001

ORIGINAL

			_ For	• •				of Health and			•	1 60	0.0
			1 - State Registrar			Cer	tificate	of Death		Rag. No	200/	163	22
	Physici		1. Decedent's Name (First, Middle, L	met for	F	Bu	04	n	2. Date of De	eath Day	C ZOC	3. Time of	Death M
,	/Medio Examin		4a. Facility Name (If not institution, ga	ve street and number)				wn, or Location of Dea	th	4c.	County of Death		
	Funeral Director		Longview Nursi 5. Social Security Number 6. 217-07-8010			last birthday) Yrs.	If Under 1	chester Year If Under 24 Hrs Days Hours Min	(Month, D	rth	Co	splace (State of intry)	r Foreign
	ō		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ation					10d. Inside Cit	v Limits
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	ţċ	Penn. Yor	k		anovei						1 ☐ Yes	
	or 28s	Directo	10e. Street and Number				10f. Zip C			10g. Cit	izen of What Co	intry?	
	eath v	Funerai	1641 Art Dri	V C	ver in II	S 13 V		7331	Specify Ves or N		J.S.A. 14. Race - Ame	ican Indian	
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other than "naturely, or itema 23a or 28a-f show important: if time 27 is marked other than "naturely, or itema 23a or 28a-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1)2] Yes 2 N If Yes, Give 1 9/4abor Dete: 4	0			it of Hispanic Origin? (.) Cuban, Mexican, Pue XNo Specify:	rto Rican, etc.)		Black, White, etc. Specify: White		
<u>ဂ</u>	n 72 ho "natur edical	Completed	15. Decedent's I (Specify only highest g	ducation rade completed)		16a. Deced	ent's Usual (Occupation done during most of wo	orking	16b. K	ind of Business/	ndustry	
7 7	d within giene. or then "	dmo:	Elementary/Secondary (0-12)	College (1-4or 5-	+)			Mechanic		Mar	ctin Ma	rietta	a
and	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middle	, Maiden	Sumame)		
7	hould d Men narke natic	ဥ	William C. 19a. Informant's Name/Relationship			10h Mailie	- Addraga /S	Cora E	ace Br		v Tourn State 7	in Code l	
Z	and 2 she salth and n 27 ie m	1	Ruth Brown - w			1		Dr. Hanov				p Code)	
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition ț☐ Burial 2 ☐ Cremation 3	Domouni from State	20b. P	lace of Disposemetery, crem			Date		ocation - City or	own, State	
Baltimor	permit. Pages Department of Important: if it eny injury or o		4 Donation 5 Other (Spec	ify)	Ne			Cem. May					
pa	Depar Depar Impo eny ir		21. Signature of Funeral Service Lice	ensee		22	Name and	Address of Facility Economic Dr	khardt	Fur	neral C	hapel	P . A
			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	mplications that caused y one cause on each lin	θ.	n. Do not ente	or the mode o	of dying, such as cardia	c or respiratory a	ırrest,	.er, mo	Approximate Interval Betwonset and D	veen
	Physician /Medical	ì	Immediate Cause (Final disease or condition resulting in death)	a. 1972			reli	e car	ON VA	PC	uley	Oriset and E	· Oalii
	Examiner		1	Due to (or as a	conseq	uence or);				Le	Lay		
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
•	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	conseq	uence of):							
-	e × e	Ical		d									
Ď X	certific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	of pregna	incv					22d Date of deli		
.O. BOX	the death by the atter ached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 1 9 ☐ Unknown	2 ☐ Feta	death 3 🗌	Ectopic preg Other (speci			23d. Date of delivery Month Day Year			ear
cords, r	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	β	Part II. Dther significant conditions	contributing to death bu	t not resi	ulting in the un	derlying cau	se given in Part I.		tobacco u Yes 2	use contribute to	_	eath? Inknown
Dae I	The law resete hes be	Completed							24a. Was auto perfe 1 Yes	an psy ormed? 2021No	prior to death?	opsy findings a completion of ca	ivailable iuse of
\	sician: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:				Other	ath (Check only				
5	Attending Physician: In death. Sector: After this certification by the funeral director.	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	,	ER/Outpatient 28b. Time of		Injury at	Home 5 ☐ Res 28d. Describe			ify)	
	endin eath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident investigation	1	rear)	Injury	М	Work? 1 ☐ Yes 2 ☐ No					
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At ho . (Specif)	ome, farm, stre	et, factory, o	ffice	28f. Location (City or To		d Number or Ru)	ral Route Numb	er,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Cartifying F (Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	av amin a	tion and/or inv	actigation in	my opinion doath acc	urrod at the time	data and	alaca and due	to the equipolat	
	To the within To the compl	Me	29b. Signature and title of certifier	06	7		29c. L	icense number	_	29d. Dat	te signed (Month	Day, Year)	
			· clad	DOVI			- 6	128/0	2	11 kc	y 18,	2007	<i>,</i>
	O.j.		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, f	Thi) A	icense number 1977 2 Suite 2	00 2120	9	,		
	Sta		31. Date filed Month, Day, Years	7 32. Registra	r's Signa	ture		- June	->				
	Registr	ar	8132.11 to T 700	The state of the s	da	To say							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ϊ18**,** Ruth N. Brown May 2007 12:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Sep. 25, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 201 213-20-0778 82 Maryland Director Yrs Usual Residence of Decedent filed within 72 hours after death with the Maryland t0a State 10h County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show treumatic event. the Mudical Examinar must be notified at MD Carroll Director Westminster 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 545 Locust Ave. 21157 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be flik ment of Health and Mental H; tant: If item 27 is marked oth Be Norman E. Fritz, Sr. Elizabeth M. Stocksdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339 North Houcksville Rd. Hampstead, MD 21074 Enoch Earl Brown, Jr. / Son other 1 20b. Place of Disposition (Name of Evergreen Memorial Gardens 20a. Method of Disposition

XXBurial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State ö permit. Page Department of Important: If any injury or QDCE. 4 □ Donation 5 □ Other (Specify) 5/22/07 Finksburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 repen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Inferchion Physician Due to for as a consequence of): disease or condition resulting in death) Dels /Medical Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Quality for as a consequence of use as the burial-transit The law requires that the death certificate be executed end resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Rilune, Acrhe 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an hes autopsy performed? Yes 2 No certificate 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1XInpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and class as district the cause(e) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H53939 RO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Imancel DO; 218 hashing ton Heights Med. Ctr; Westminster Babak 31. Date filed (Month Day, Year) 32: Registrar's Signature State Libert . Registrar

		٨	mend #1, perMD, G867, 5/	State of Maryland		riment of F ificate of		ntai mygie Reg.	-200	7 1	6324
			1. Decedent's Name (First, Middle, Last)	MARIORI	I B1	Act	2.	Date of Death	Day		Time of Death
	Physici		12 1 1 - 12	arjorie Black				Month		Year	5 30m
4	/Medic Examin		4a. Fecility Name (If not institution, give s	street end number)		11/	4b. City, Town, or Local	tion of Death	4c. County	of Death	
	EXAMI	E	MARY LAND	BARISIT	- Aga	1 Home	Baltin	noke	_		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	lest birthday)	If Under 1 Year		. Date of Birth (Month, Dey, Ye		9. Birthplace	(State or Foreign
	Funeral Director		578-56-8920 10	M 20 F 65	Yrs.	Months Deys	Hours Min.	5-1-	1941	lorth C	arolina
			Usual Residence of Decedent								
	how how	.	10a. State 10b. County	10c. City	y, Town or Loce						nside City Limits ▼ Yes 2 □ No
	e-f.s	Funeral Director	MD		Balti	more					X 163 2 110
	1 th	j.	10e. Street and Number			10f. Zip Code		10g.	. Citizen of W	hat Country?	
	th wi	al	2801 Rayner Avenue				216		USA		
	dea dea	ner	11. Marital Status unk	12. Was Decedent Ever in U, Armed Forces?	S. 13. W	as Decedent of I	Hispanic Origin? (Specil an, Mexican, Puerto Ric	fy Yes or No- can, etc.)		e - American Ir k, White, etc.	idian,
21215-0020	s 1 end 2 should be filed within 72 hours efter death with the Maryland if Health end Mentel Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show eitem 17 is marked other than "natural", or items 23s or 28e-f show other treumstic event, the Modeal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		□Yes 2XINo			Specify	blac	k
0-0	2 ho	Completed	15. Decedent's Educ (Specify only highest grede	cation	16a. Decede	ent's Usual Occup	pation	16	b. Kind of Bu	isiness/Industr	у
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Maryland	Went Went Treed	To I	James William	S	y-			ella Wil			
a	shod l		19a. Informant's Name/Relationship (Ty	•			t end Number or Rurel F			State, Zip Coo	le)
	1 end 1 Health sm 27 i		Margaret Scott/sis				ow Street 1			20737	
Baltimore,	permit. Pages 1 end Depertment of Health Important: If item 27 any injury or other ti once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 🕅 Other (Specify)	emoval from State	Place of Disposi emetery, crema	ition (Neme of atory or other pla	ace)	Date 20	c. Location -	City or Town,	State
Balti	permit. Page Depertment o Important: If any injury or once.		21. Sig. ture Funeral Sent License	åde, Director	22. S t	Name and Addr tate Ana altimore	ess of Facility atomy Board e, MD 2120		Baltir	nore St	reet
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death					t,	Apr	oroximate
	Physician		shock, or heart failure. List only or	ne cause on eech line.						On	erval Between set and Death
1	/Medical		Immediete Ceuse (Final	Makers	· har Him	Capci	nama od	pana	eas	2	oday1
	Examiner		disease or condition resulting in death)		or as a consequ		Marie 2			30	5 = 124)
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	uted d ansit	Ē	Sequentially list conditions)	r es a consequ	ience of):	new 2	.,			
oʻ	exec en ar	ŭ	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		The Line		girlican of				<i>y</i>
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	tifica ng ph es th	_	resulting in death) Lest	Llyn	atmola	1					
Box	h cer endir use	Z.		777			4.00				
	deat e ett	읈	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause g	iven in Part I.	23b. Did toba	acco use co	ntribute to the	ceuse of death?
P.O.	that the ed by the detach	/ Phy	Schizephronia					1 □ Yes	2□ No	3 🗌 Probabl	y 4⊠Unknown
Division of Vital Records,	r requires that the death certifi been signed by the ettending should be detached for use es	Completed by Physician/N					Marine and a second and a second as a seco	24a. Was an a performe	autopsy ed?	availat	autopsy findings ole prior to etion of cause th?
Re	sicien: The law certificate hes t director, page 2 s	를						1 Vos	2 17 No	1 □ Ye	_ /
ā			25. Was case referred to medical				26. Plece of Death (
₹	Physicien: this certific ral director,	Be C	avaminar? /	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA 0	ther: 4 Vursing Home		ce 6 ∏Oth	er (Specify)	
n of	2 .07	lon: To	27. Manner of Death 1 □ Natural 5 □ Pending	28e. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Inju		3d. Describe how			
ivisio	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre fy)			Bf. Location (Stre City or Town,		oer or Rural Ro	oute Number,
	tal or sall or	Se									
	• Hospi 124 hou • Funer Hetely fil	dical	29a. Certifier 1 🛈 Certifying Physical (Check only one) 2 🗆 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner steted.	owledge, death ation and/or inv	occurred et the t estigation, in my	time, date end place, en opinion, death occurred	d due to the ceu d et the time, date	se(s) and ma e and place,	anner as states and due to the	cause(s)
	Fo th Withir Youth	M	29b. Signature and title of certifier			29c. Licer	nse number	290	d. Date signe	d (Month, Dey	, Yeer)
	- >- 0			NESMA			304014		5-1-20	(7	
			30. Name and address of person who co	ompleted cause of deeth (Iter	m 23a) (Type, F	Print)					
				aidenchaice 1	bure c	Calonsvill	le mb v	1228			
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	seeks					
	Regist		MINI T 9	July San San	17						

Mongane Black

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month 14:45P^M Ruth Louise Brett May 9. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 1 ☐ M 2 🖵 F 577 01 1834 Director 0ct 15, 1915 WashingtonDC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Marvland Calvert 1 ☐ Yes ZYNo Director St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 6775 Ben Creek Road J. Hyglene. other than "natural", or Items 23a. vent, the Medical Examiner must it 20685 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 2 Specify: White 3)(□)(Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UPErator Elementary/Secondary (0-12) College (1-4or 5+) Telephone White House Switch Board 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry James Daniels Flossie Ann Barnev မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Smolinski (Daughter) 6770 Ben Creek Road, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 14 Date 200 / 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once, 1 Burial 2 □ Cremation 3 □ Removal from State Clinton, Maryland 4 Donation 5 ☐ Other (Specify) Resurrection Cemetery 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD20795 234. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE CHF EXACERBATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COTALIG CARDIONY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: PULMONARU Due to (or as a consequence of): CND Physician/Medical STAGE IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION Yes 2 No 3 Probably 4 Unknown SMOKING 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2**)**∭No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ No P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed and I-tran physician ar s the burial-t ivision or Vital Records, P.O. Box 68760, attending p for use as 1 certificate vithin 24 hours and
To the Funeral Dir To the Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IX WASSEMA DRIVE 110 HUSDIARL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD

MAY 1 8 2007

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0064961

SUITE #310.

29d. Date signed (Month, Day, Year)

,20678

5/10/07

PRINCE FREDERICK

			For State Registrar	State of Maryland /		rtment of H ificate of L			jiene () () 7	16326
			Decedent's Name (First, Middle, Last	st)				2. Date of Dea	th		3. Time of Death
П	Physici		Edna	Mae		Char	mbers	Month O5	16 20	Year 007	6:00p. M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or		1	4c. County		, o. oop.
	Examin	٠.	3418 Rockwood A	Ave		Balt	imore				
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last b	irthday)_	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	Vear	9. Birthp	place (State or Foreign
	Director		212-26-0099	□м Х□г 77	Yrs.	Months Days	Hours Min.	03 16		CODI	MD
	pu ,		Usual Residence of Decedent	40-01-7							
	aryla.	_	10a. State 10b. County	10c. City, Tov						1	0d. Inside City Limits 1 ☐ Yes 2 🔯 No
	Be-f	5	MD NA	Bal	timo						
	vith th	<u>=</u>	10e. Street and Number			10f. Zip Code		1	10g. Citizen of V		ntry?
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	er de Item	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cubai	spanic Origin? (S) n, Mexican, Puerto	o Rican, etc.)	Blac	e - Amend k, White,	ean Indian, etc.
36	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Iteme 23a or 28e-1 ehow event, the Medical Examinar must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:	1[⊒Yes 2. TXNo	Specify:		Specify	^л В	lack
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9	illed wi Hygien other th	Be C	17. Father's Name (First, Middle, Last)			l l	18. Mother's Nam	ne (First, Middle,			
<u>a</u>		To B	Ernest Thomas				Christ	ine Wat	son		
Baltimore, Maryland 21215-0036	s 1 and 2 should be if Heelth and Mental item 27 is marked o other treumatic eve		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing	Address (Street a	and Number or Ru	ral Route Number	r, City or Town,	State, Zip	Code)
Σ	and 2 eeith a m 27 is		Claudette Alsto	on-Daughter 5	004	Levinda	ale Roa	d, Balt	imore	Md	21215
ē,	f Her Item othe		20a. Method of Disposition	20b. Place	of Disposi	tion (Name of atory or other place			20c. Location -		
Ë	permit. Pages Depertment of I Important: If It eny injury or o		1 ☐ Xurial 2 ☐ Cremation 3 ☐ 4 ☐ DonAtion 5 ☐ Other (Specification 5 ☐ Other (Specification 2 ☐	Hemoval from State				22/2007	Randa	alls	town, Md
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			23a. Part1 Enter the disease, or com	plications that caused the death. Do						Tiu	Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final			A					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. CEREBROVASCU		MECHO	ENI				
	Examiner			200 10 (01 23 2 0011304201100	o 017.						
		6	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	a of).						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events								
a î	exec an en rial-tr	Exa	resulting in death) Last	Due to (or as a consequence	e of):						
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ROX	The law requires thet the death certifi vie has been signed by the ettending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal deat	th 3∏c	ctopic pregnancy			23d. Dat	te of delive	
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of death		Other (specify)			Мо	nth	Day Year
J.	by the detached	hys	9 Unknown	9LI OHKHOWN							
	signed t	by	Part II. Other significant conditions of	-	in the unc	derlying cause give	in in Part I.	23e. Did to	bacco use cont	nbute to th	ne cause of death?
ğ	w require been signation	ed	HYPERTENSION	N				1 🗆 Y	es 2 XNo	3 Prob	ably 4 Unknown
ပ္က	awre	plet						24a. Was a autops		Vere auto	psy findings available mpletion of cause of
ř	The lav	Completed						perfor	med?	death?	20 No
Vital Records,	sicien: T certificet rector, pa	0	25. Was case referred to medical				26. Place of Dea	th Check only or			
	Physicien: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient	3□ DOA Othe	4 Nursing H	ome 5.2 Resid	ence 6 □Oth	er (Specif	y)
Division of	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury 28b.	. Time of Injury	28c. Injury Work	at	28d. Describe h	ow injury occur	ed	
<u></u>	ath. ath. or: Af	atic	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		res 2 □ No				
<u>≅</u>	r Atte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (S. City or Town		er or Rura	I Route Number,
ā	tal or rs eft	Cer		3, 1,7,7,							
	To the Hospital or Attanding Physicien: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Exam	ysician: To the best of my knowledgeniner: On the basis of examination a	ge, death o	occurred at the time	e, date and place, pinion, death occur	and due to the c	ause(s) and ma	nner as st	tated. the cause(s)
	thin 2 the mplet	Med	29b. Signatury and title of certifier	and manner stated.		29c. License			29d. Date signe		
,	7. ₹ 5. 8	28	L C	Blance NIA					A 4		
			Jonna C	RAIME MID			1678		May 1	111	2007
	3		30. Name and address of person who				. him				
		• 0	Smia Blome 31. Date filed (Month, Day, Year)	32 Begistrar's Signature	ot B	altimor	T MY				
ŧ	Sta Registr		MAY 2 1 2	22 S Greene S 32 Registrar's Signature	1	Alles					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** Catherine J. Ches 17 May 8:12AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hpkins Bayview Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 1 F Director 162-22-8238 78 June 3,1928 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 21224 7402 Fait Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 1 and 2 should be filed within 7 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years year Accountant Banking permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Campanella Josephine Vella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7402 Fait Avenue, Dundalk, Md. 21224 JoAnn Airev Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 22,2007 Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, Lauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA ၉ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After Certification: 1 Natural 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.O. Records, or Vital Division To the Hospital or Attending within 24 hours after death To the Funeral Director: completely filled in by the

7

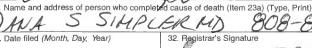
Medical

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

29a. Certifier







1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D35170

29d. Date signed (Month, Day, Year)

S. CONKLING ST BALTO HID 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Barbara C. Carter 0:45AM mai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Lanham Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F 70 577-52-8582 Director 2, 1937 Washington, D.C. Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1√2 Yes 2 No Directo Maryland Prince Georges Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or United States 20737 4009 East/West Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 1 ☐ Yes 2 No Specify. Specify: Black \$ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Private Day Care Provider 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Young is marked Earl Stevenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9531 Nottingham Dr. Upper Marlboro, Md. permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Timothy A. Carter / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 18,2007 4 Donation 5 ☐ Other (Specify) Harmony Memorial Landover, Md. 22. Name and Address of Facility 21. Signatue of Funeral Service License exander S. Pope / P.A. 38 Mariboro Pike/Forestville, MD. 20747 23a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bu (MONAR **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine he law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 ☐ Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Mnknown 1 Yes 2 No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy death? 1 □ Yes 2 □ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day Year) 29b. Signature and title of pertiner

State Registrar

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760.

MDD 58446

,8118 GOOD LUCILRd.,

Lanham, MIS. 20706

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:19 AM M May 10, 2007 Joseph Alan Clise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville Carroll 5836 Oakland Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 84 Oct 25, 1922 216-12-0693 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County item 27 is marked other than "naturel", or items 23a or 28a-1 show other treumstic event, the Michael Examination must be notified at 1 ☐ Yes 2√2 No MD Carroll Svkesville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5836 Oakland Road 21784 USA Funera 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after and Mental Hygiene. 1 MYes 2 No
If Yes, Give
Year or Dates: 43-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 end 2 should be fi of Health and Mental H litem 27 is marked of Joseph Chapman Clise Anna Marie Memmert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5836 Oakland Road Sykesville, MD Margaret Clise/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition permit. Pages 1
Department of H
Importent: if ite
any injury or oti 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Sign ture Ronal dervice Licensee Pire 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 25a. Pant 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic CASTructue /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualty for as a consequence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed and a Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FSChmic Centres my a rury page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: After this certification funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director; , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 12 2007 029085 Cley leaves 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5310 00 COURT ch 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 2 1 2007 State lava Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death O7 Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MD Wicomico HOSPICE 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 😾 F Months Days Hours Director 212-30-0740 73 June 10, 1933 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Bearberry Road 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Balthaser Decker Helen S. McCubbin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coastal Hospice at the Lake 351 Deershead Road Salisbury, MD Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Sp 4 Donation 22. Name and Address of Facility 21. Signa State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastati **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the atte Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 22 No page 1 | Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) 26 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ~ Inpatient 3□ DOA 2 ER/Outpatient ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury (Month, Day Year) 5 Pendina investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 1733 Solut, MO2180-Coastal

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

2007

Registrar's Signature

Physician /Medical Examiner

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Medical Certification: To

The law requires that the death certificate be executed

Box 68760

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Division of Vital Records.

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Pages 1 and 2 should be filed within 72 hours after death

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21215-0036

Baltimore, Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transit

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

9 Unknown

5 ☐ Pending investigation

6 Could not be

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Yes Yes 2 🗆 No 27. Manner of Death

Natural

2 Accident

3 C Suicide

4 - Homicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

Parel mo

D005941

29d. Date signed (Month, Day, Year)

7

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) ratel

2200 mn Kernan Drive, 32. Registrar's Signature

Baltimore

31. Date filed (Month, Day, Year) MAY 2 1 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joseph Wells Clifford May 14, 2007 3:27 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase 4108 Rosemary Street Montgomery 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F Months Days Hours Min. Director 279-12-3729 85 Jan. 21, 1922 Ohio Usual Residence of Decedent death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 XYes 2 No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4108 Rosemary Street Funeral 20815 United States permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important if frem 27 is marked other than "" any Injury or other traumotic." 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No þ Specify: Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ International Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Clifford မ Marie Wells 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Clifford / Wife 4108 Rosemary St., Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2007 Bethesda, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda-Chevy Chase, Inc. 7 M00335 Bethesda, Maryland 20814-350 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sarcoma /Medical Due to (or as a consequence of): **Examiner** Valvular heart disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-trai Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an cete has autopsy performed' 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one)

P.O. Box 68760. Division or Vital Records, Hospital or Attending Physician;

director funeral hours after death uneral Director: filled in by

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Certification:

Medical

1 ☐ Yes 2 X No

27. Manner of Death

2 Accident

4 Homicide

(Check only

3 Suicide

29a. Certifier

1 X Natural

24 hours a completely within 2 State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

1 Inpatient

28a. Date of Injury (Month, Day Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Dav. Year)

Other: 4 Nursing Home 5 🕱 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

May 14, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5454 Wisconsin Ave., 1300, Chevy Chase, Maryland 20815 Lisa McGrail, M.D.,

2 ER/Outpatient 3 DOA

M

28c. Injury at Work?

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

31. Date filed (Month, Day, 32. Registrar's Signature

5 ☐ Pending investigation

6 Could not be determined

07-03738

Bernard R. Cole, Jr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 16333

		For State		Cert	ificate o	t Death					eg. No.			=:
Physician		Decedent's Name (First, Middl	le,Last)						2.	Date of Dea	ath Day	Year	3.	Time of Death
Examine		Bernard R. C	'ole Jr] [Month May 16, 2	2007			1215 hrs
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Funeral	5	Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	Months	Days	Hours				// TF	oreign	Maryland (maryland
Director		218-62-5782	1 xM 2 F	52	Yı		Daye			06/02/	1954		Count	try) 1
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21215-0036 uid be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f shr c event, the Medical Examiner must be notified at once	ompleted	Elementary/Secondary (0-12		(1-4 or 5+)	during	most of work	ing life. I	DO NOT u	ise retire	d)	1			
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5-0036 led within tygiene other tha	鬞닏	12 17. Father's Name (First, Middle	- 1 1		Mea	t Cutt	<u>er</u> 1₁	8 Mother's	Name (First, Middle	, Maiden S	Surname)	ICILI.	119
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21215-0036 Juld be filed within 7 Mental Hygiene marked other than		Bernard Roland	d Cole, S	r	100 14-3	ling Address	(0)	VIVI	an C	rawle	umber Cit	v or Town	State	Zin Code)
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e, MI Land 2: Health 8		20a. Method of Disposition			Place of Disp crematory or	osition (Nam	e of cerr	netery,		Date	20c. L	ocation - C	JILY OF I	Own, State
nore, MD 2121 gaes I and 2 should be fi in of Health and Mental it: If item 27 is marker other traumatic event,	П	1 Burial 2 X Crematic		from State	,	. ,	Tr		0E /1	o /200.	7 Pa	ltim	ara	Maryland
Eim Pa Emen	1	4 Donation 5 Other		I Me	tro Cr	emator	V 11 Address							F/H, P.A.
Baltimore, permit. Pages I an Department of He Important: If ite Important: If ite injury or other tr		Signature of Funeral Service												
ш & Д = .=		23a. Part I. Enter the disease,	7 (- 1	30.00	4	611 Pa	rk t	lats.	AVE	respiratory	LTIMO	re. I	rt	Approximate Interval
ysician		23a. Part I. Enter the disease, failure. List only one caus	r complications the se on each line.	causer the death	i. Do not ente	er the mode o	i dynig,	30011 00 00	1 0.00 01	roop. atory				Between Onset and Death
Medical	- 1	Immediate Cause (Final disease	Narce	otic (morph	ine and	Methado	one)	intoxi	catio	חב				Deatil
Examiner	- 1	or condition resulting in death)		s a consequence of	of):								;	
		Sequentially list conditions,	b											
	힐	if any, leading to immediate		s a consequence	of):									
	盲	cause. Enter Underlying Caus (Disease or injury that initiated	C		-6):									
at. g	Examiner	events resulting in death) Las		as a consequence	or).									
and tran	픪		d											
tal Records, P.O. Box 68760, cinn: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	n/Medical	XUNPENDED	4/250	2 7,28a-f,p	erME, G	868, 6/1	1/07	TT						
8760, tificate being physic as the bur	ě	IF FEMALE:		es, outcome of pre-							230	d. Date of		
187 Triffic Tr	١	23b. Was decedent pregnant in past 12 months?	1 44	ve birth	2	Fetal death	3	Ectopio	c pregna	ncy		Month	D	ay Year I
x 6 th cer	<u>:</u>			egnant at time of d	leath 5	Other (Spe	cify)				- 1			
Records, P.O. Box 68 The law requires that the death cert icate has been signed by the attendir page 2 should be detached for use a	Physicia			nknown					-	00 - D	idiahaana	uaa contri	ibuto to	the cause of death?
tr the		Part II. Other significant con	ditions contributir	ng to death but not	resulting in t	the underlying	cause (given in Pa	art I.					
B the	by									1	Yes 2	_No 3	Proc	pably 4 🗸 Unknown
den s	Completed	ń								24a. W				topsy findings available completion of cause of
Orc aw re as be 2 sho	음										utopsy erformed?		death?	
Pec ate h	E									1 🗸 Y	es 2 1	10 1	✓ Ye	es 2 No
E i i i i i i i i i i i i i i i i i i i		25. Was case referred to med	fical		100		26.Plac	e of Death	(Check	only one)			_	
Vital Records, ysician: The law requirinis certificate has been secretificate, page 2 should	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpa	tient 3 [AOC	Other ₄	Nursir	ng Home 5	Reside	ence 6	✓ Other	r: Scene
of Vit ling Physic After this of funeral dire	-	1 Yes 2 No 27. Manner of Death	.28a. [Date of Injury Month, Day, Year)	28b. Time	e of Injury	28c. Inju	ury at Wor	k?	28d. Descr	ibe how in	jury occurr	red	
ding	ou	4			D 1 1	0.00	1	Yes 2X	No	unk				
sio deatl deatl ctor:	äti		TIK.	1.5/16/2007 Place of Injury - At		2:00 am	v office	building, e	etc.	28f. Locati	on (Street	and Numb	er or Ru	ural Route Number, City
Division of Vital Records, P.O. Ind or Attending Physician: The law requires that the stafer death. In Director: After this certificate has been signed by the funeral director, page 2 should be detace.	ij			cify) reside		Street, lactor	y, 011100	D0ug, 0						timore, MD
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	4 Homicide					-							
Hos 24 ho Fun	a	29a. Certifier 1 Certifying	g Physician: to the	e best of my knowle	edge, death o	occurred at th	e time, d	date and p	lace, and	d due to the	cause(s) a	nd manne	r as stat	red. ne cause(s)
Di To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical I	g Pnysician: 10 the Examiner: On the ba and man	asis of examination ner stated.	and/or inve					acule ullie,				
To To Com	Me	29b. Signature and title of cer				29	c. Licen	se numbe	r				,	onth, Day, Year)
		11	111	7 -	70		O.C	.M.E.			Ma	ay 17, 20	007	
al a		Miroda	ell,	~ X J /	121 M	VIr								
h 1		30. Name and address of per		cause of death (Ito sistant Medica	em zoa) I Fyamine	er 111 ₽	enn S	treet. B	altimo	re, MD 21	1201			
V		Theodore M. King,		- A										
S	tate	KH /I V I	9 2007 3	2. Registrar's Sign	A A	- Sugar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 05:55 AM 05 Robert Irving Dawson 15 2007 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) DALISBURY VICENICO NEDICAL KEGIONAL (ENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 23, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days 1**X** M 2□ F Massachusetts 019-12-3820 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 1101 S. Schumaker Drive #205 21804 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 42–46 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) psychology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George I Dawson Laura Belle Chase 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Muriel Dawson/spouse 1101 S. Schumaker Drive #205 Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Femeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part . Enter the disease, or compelications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death therosciesotic Cardiovascu Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lipiry or other traumatic event, the Medical Examiner must he provided.

Baltimore, Maryland 21215-0036

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

State

attending physician and for use as the burial-tran signed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

After this certificate

The law requires that the death certificate be executed

Box 68760,

Ö

Records,

Division or Vital

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

5 Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

2 No 1□ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

2 ER/Outpatient

28b. Time of

Injury

3 DOA

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. physician certificate has After this

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Sarah Louise DiStefano 9:05 A. May 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 446-30-2429 Oct. 27, 1935 Oklahoma Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified et 1 ☐ Yes 2 No Directo Maryland |Montgoemry Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8908 Paddock Lane 20854 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ρ Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Program Assistant Dept. of Agriculture permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is merked othe eny liquiry or other traumatic event once, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Byron E. Williams Beulah Potts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8908 Paddock Ln., Potomac, Maryland 20854 Anthony V. DiStefano / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ay 22, 2007 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service R22 Name and Address of Facility Robert A. Himphrey Funeral Home/Rockville, Inc. M00896 300 West Montgomery Ave., Rockville, MD 20850-2805 Approximate Interval Between Onset and Death 23a. Part1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** a. Lung Cancer 5 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 21 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1

∏ Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m. Haggerty m) D32407 May 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D., 9707 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Elliott Jr. Joseph Harry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital hoseda Baltimore Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 31,1935 **Funeral** Months Days Hours 1 XM 2 ☐ F 217-30-3963 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 XNo Director Middle River Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If Item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Exa<u>miner must be</u> 1 21220 USA 22 Hammock Trail Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: 3 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stock Chaser General Motors 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Joseph Elliott Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2: Health a 22 Hammock Trail, Middle River, Maryland 21220 Edith Elliott wife permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State May 21,2007 Baltimore City, MD. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Inature of Funeral Service License Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease or complications that caused the death. In one enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Neutro penic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 🗌 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours at er death e Funeral Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

b

State Registrar

31. Date filed (Month, Day, Year)

N

Frank

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month May 18, 2007 /Medical Kenneth Reardon Edwards 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12807 Caldwell Street Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of (Month) **Funeral** Days Hours 1 ☑ M 2 ☐ F 525-54-3666 Director 75 Aug. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 28a-f show at notifled Directo Maryland Montgomery Rockville 10e. Street and Number ns 23a or 2 must be n 10f. Zip Code 12807 Caldwell Street 20853 Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If fleam 27 Is marked other than "natural", or Items 23a ury or other traumatic event, the Medical Exeminer must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation

College (1-4or 5+)

4

	4b. City, Town, o	or Location of Death			4c. County	of Deat	h	
	Rockvi	.11e			Mo	ntgo	mery	
st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth			hplace (State or untry)	Foreign
Yrs.	Wionth's Days	Hours Will.	Aug. 7,				Mexico	
Town or Lo	cation						10d. Inside City	Limits
kvill	2						1 ☐ Yes	2 X]No
	10f. Zip Code			10g.	Citizen of V	What Co	untry?	
	20	853		Ţ	Unite	d St	ates	
13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-		e - Ame	rican Indian,	
	□Yes 2X No		,		Specify		hite	
16a. Deced	ent's Usual Occup kind of work done	pation during most of work ed)	ing	16b.	Kind of Bu	usiness/l	ndustry	7
Direc	tor of S Train	kill Impr	ovement	1	U	nion		
-		18. Mother's Name	e (First, Middle	, Maio	len Surnan	ne)		
		Anna Ma	rie Rea	ardo	on			
19b. Mailin	g Address (Street	and Number or Run	al Route Numb	oer, Cit	y or Town,	State, Z	ip Code)	
1280	7 Caldwe	11 Street	, Rocky	7111	Le, Ma	aryl.	and 208	353
ce of Dispos netery, cren	sition (Name of natory or other pla	(20)	Date				Town, State	
e of He	aven Ceme	tery May 200	74,	Sil	lver :	Spri	ng, Mary	yland
Ro	Name and Addre	umphrey Fun	eral Hom					

6:05

Α

Dav

Physician /Medical Examiner

physician and s the burial-trans

as

use

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signed by the a

page 2 s has

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

or Attending

Hospital Funeral

To the the

after death.

the

filled in by

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau

Be

2

Examine

Physician/Medical

9

Completed

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

IF FEMALE:

Immediate Cause (Final

disease or condition resulting in death)

Elementary/Secondary (0-12)

Riley Edwards

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

1 N Burial 2 □ Cremation 3 □ Removal from State

Maria A. Edwards/Wife

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses William a ton

23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death

9 Unknown

4□Pregnant at time of death

Renal Failure Due to (or as a consequence of): Due to (or as a consequence of): Bacterial Endocarditis

M01173

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

300 W. Montgomery Avenue, Rockville, Maryland 20850

23d. Date of delivery Month Day

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Decubitus Ulcer

2 □ No

Diabetes Mellitus

24a. Was an autopsy perform 1☐ Yes 2X No

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 ☐ Pending investigation 1 X Natural

1 Inpatient 2 ER/Outpatient 3 DOA (Month, Day Year) 6 ☐ Could not be determined

28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of cer

MAY

29c. License number D41245

29d. Date signed (Month, Day, Year) May 18, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Jack Epstein, M.D. 10810 Connecticut Avenue, Kensington, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200° Day Month **Physician** 0350M George J. Fitz a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Harford Belair If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 16, 1923 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 XM 2 ☐ F 84 215-18-8771 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Ex-miner must be notified at 1 ☐ Yes 2 XNo Maryland Harford Belair Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Langford Place 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Welder 12 years year Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 is marked o Anthony Fitz Mary Hromy 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 Urey Road, White Hall, Maryland Mary Helen Green Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If ite any Injury or ot once, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State May 22,2007 Gardens of Faith Rosedale, Maryland 4☐Donation 5☐Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 ure of Funeral Service Licenses 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial **Physician** Days disease or condition resulting in death) /Medical or as a consequence of): Examiner oronary Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) cale has reen signed by the properties are properties and properties are properties. 1 ☐ Yes 2 ☐ No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 V robably 4 ☐ Unknown 1 ∏ Yes 2 ∏ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1∐ Yes 2 000 1 ☐ Yes funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

requires that the death certificate be executed Records, P.O. Box 68760 Division or Vital or Attending Physician:

72 hours after death with the Maryland

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permit.

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death.

State Registra

30. Name and address of person 31. Date filed (Month, Day, Year) 2 MAY

29b. Signature and title of certifie

(Check only

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no completed cause of death (Item 23a) (Type, Print)

500 Upper Chesapeake Drive, Bel Air, 21014

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 18 2007 Margaret Lola Fadely May 5:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll 8. Date of Birth (Month, Day, Year) Feb. 3,1917 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 😾 F Yrs. 160-10-4073 90 Maryland Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes XXNo Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 3486 East Lawndale Rd. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14 Pace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items dical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes XXNo Specify þ Specify: White XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aqı Secretary State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nelson Miles 27 Is marked traumatic e Lo1a Hughes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Wilson Fadely, Jr. Son 10534 Martellini Dr. Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 ☐ Other (Specify) Lakeview Mem. Park May 21,2007 Sykesville, MD. 22. Name and Address of Facility 21. Signature of wherel Service Licens Eckhardt Funeral Chapel P.A 11605 Reisterstown Rd. Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ummu Due to (or as a consequence of): samscu Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA

Physician /Medical Examiner The law requires that the death certificate be executed

the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

physician as attending for use as has ge 2 s ď Certification: after death I Director: / d in by the f within 24 hours aft To the Funeral Di completely filled in Medical

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

688 Poole Road, Westminster, A. M.D. C. 32. Registrar's Signature

			For State Registrar	State of	Marylar		artment o			_	giene Reg. No.	007	16340
8	i jedi		Decedent's Name (First, Middle, I	.ast)						2. Date of De	ath		3. Time of Death
	Physici /Medic		Dorothy A. Faulk	ner						May 16	, 20°0	7 Year	3:55 А. м
	Examin		4a. Facility Name (If not institution, g				4b. City, Tow		on of Death		1 .	ounty of Dear	
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72	Funeral Director		578-10-4498	Sex 7 1 ☐ M 2 ☑ F	96	last birthday) Yrs.	If Under 1 Y Months Da	ays Hour	der 24 Hrs.	8. Date of Bird (Month, Da July 2	y Year) 8, 19	Co	hplace (State or Foreign ountry) ginia
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Mary -1 eh	ţō	Maryland Montgoe	mry	Roc	kville							1 ☑ Yes 2 ☐ No
	h the	irec	10e. Street and Number	-			10f. Zip Coo	de			10g. Citize	en of What Co	ountry?
	th wit	aiD	8 Baltimore Road				20850	C			Unite	ed Stat	es
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36	s afte	by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			I ☐ Yes 2]{[No Spec	ify:		s	Specific:	
ô	hour	ed b	15. Decedent's	Year or Dat	es:	16a Decer	dent's Usual O	ccupation			16b Kind	d of Business	hite
7.	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f ehow the Madical Examiner must be coliffed at	plet	(Specify only highest of Elementary/Secondary (0-12)		tor E .\	(Give	kind of work do	one during n	ost of workir	ng	100.10	u 01 Du3111033	modstry
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-1 ehow apprintury or other traumatic event, the Madical Examilier must be notified at once.		19a. Informant's Name/Relationship Mary E. Farrell				_			Route Number	-		
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P.O.	thet the death certific ed by the ettending p detached for use as	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□ Pregnar 9□ Unknow	nt at time of d m	eath 5L	Other (specify	v)					
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á	ai or A s efter of in bire	Certification:	4 Homicide	building	, etc. (Specif	(y)				City or Tox	vn, State)		
	To the Hospital or Attending Physician: The law within 24 bours elter death. To the Funeral Director Attenthis certificate hes completely filled in by the funeral director, page 2	edical (29a. Certifier 1⊠ Certifying (Check only one)	Physician: To the basiner: On the basiner	is of examina	owledge, death	occurred at three stigation, in r	ne time, date my opinion, d	and place, a death occurre	nd due to the	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
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DHMH 17 Rev 1/2001

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-	Funeral		5. Social Security Number 6. S	7. Age (In y	s. last birthday	y) If Unde		er 24 Hrs.	8. Date of Birth	Balti 9.8i	rthplace (State or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or I	Location					10d. Inside City Limits
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	or 288	Funeral Director	10e. Street and Number			10f. Zip	Code		1	0g. Citizen of What C	ountry?
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89				d						- 1	
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П	Physician: The law requires that the death certifica this certificate has been signed by the attending phyral director, page 2 should be detached for use es the	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time o		Other (s	pecify)			Month	Day Year
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Division of Vital Records,	or Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, s	street, factor	y, office		28f. Location (St City or Town	reet and Number or F n, State)	lural Route Number,
	pitel ours a leral C		29a. Certifier La Certifying Ph	ysician: To the best of my k	nowledge dea	ath occurred	at the time date	and place	and due to the co	auso(s) and manner a	s ctated
	To the Mospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examone)	iner: On the basis of exami and manner stated.	nation and/or	investigation	, in my opinion, d	eath occur	red at the time, di	ate and place, and du	e to the cause(s)
	To the comp	×	29b. Signature and title of certifier			29	c. License numbe		2	9d. Date signed (Mon	th, Day, Year)
,	5		Jasueen	Yallia	L-		1285	37		5/16/67	
	1		30. Name and address of person who		em 23a) (Type	e, Print)	+ AIE	SL	ITE 20	3 BALL	MI) 21209
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature A	Sm) TI	, ,,,,			- , 8,74	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:114 NEWELL M. GERSTMYER 7.9> 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MD. MASONIC HOME COCKEYSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 1 / 25 / 1912 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2 □ F PENNSYLVANIA 95 212-07-6561 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ir than "natural", or Items 23a or 28a-t show the Medical Exercitive must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE COCKEYSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 USA 300 INTERNATIONAL CIRCLE permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene in Thaturat, or Hems 23a important: If Item 27 is marked other than "naturat, or Items 23a any injury or other treumatic event, the Madical Examiner must any injury or other treumatic event, the Madical Examiner must Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Š 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8YRS LITHOGRAPH SUPPLIES SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY L. GERSTMYER MABLE C. BRENNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2823 BENSON MILL RD. SPARKS, MD. 21152. W. RANDALL GERSTMYER(SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/24/2007 TIMONIUM, MD. DULANEY VALLEY 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility sons co. HENRY W. JENKINS & SONS C 16924 YORK RD MONKTON, MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequ **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): Box 68760. physicien 9 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No jo 5 Other (specify) 4 Pregnant at time of death P.O. 1 the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Š 99 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4♠Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation after death filled in by the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital of within 24 hours af To the Funerel D completely filled in Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state(). 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier a h (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 7600 TOWSON, MD. Ø SLEK DRIVE AYMAN AKKAD M.D. SUITE 411 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Carles MAY 2 1 2007 Registra

			For State Registrar	State of Ma	ii yiai ic		tificate of	Death	ı	Reg. No	OOD	7	160	343
A ₃	Physici		Decedent's Name (First, Middle, Las LEONARD	t)			GREBOW		2. Date of Dea Month MAY 1	ath Da	ž007 ^{Ye}	ar	Time of 2:30A	
A.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)				r Location of Death	LIVI T		County of D		307	
			JEWISH CONVALES		:R		BALTI					TIMOF		
	Funeral Director		5. Social Security Number 6. Social Security Number 1. Social Security	7. Age	97	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 03/22/	h y, Ye <i>ar,</i> 191(9.	Birthplace Country) V	(State of	r Foreign
	yland now at		10a. State 10b. County		10c. City	Town or Lo	cation						Inside Cit	
	e Mar Ba-f st	Director	NY NEW YOR	Κ	NEW	YORK							1 🗌 Yes	2 💢 No
	vith th	Dire	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What			
	ns 23	Funeral	4 E. 28TH STREET	/HUILL LA 12. Was Decedent E Armed Forces?		S. 13. V	100 Vas Decedent of H	I b lisp <i>a</i> nic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	- 1	US. 14. Race - A		ndian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🙀 N If Yes, Give Year or Dates:	lo		f Yes, specify Cub	an, Mexican, Puerto Specify:	Rican, etc.)		Black, V Specify:	Vhite, etc. WHITE		
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br	be filed stal Hyg cd other event, 1	Be C	17. Father's Name (First, Middle, Last)				LINTOON	18. Mother's Name	e (First, Middle,					TOTAL
ylaı	ould b Menta arked atic e	10E	ABRAHAM	R.		GREB0		LOTTIE					1ARK	
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (7				-	and Number or Rur						
	s 1 and f Health tem 27 other tr		SYBIL COBLENZER 20a. Method of Disposition	/ NIECE	20b. Pl	ace of Dispo	sition (Name of	JE, #608,	Date Date		ocation - City	21208 or Town,		
altimore,	Pages nent of int: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specify</i>		CORI	TOP S PORATI	BERVICE ON	05/2	1/2007	BAI	TIMORI	F. MD)	
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service Licen	see		22	. Name and Addre	ss of Facility S	OL LEVI	NSO	N & BR	OS.,	INC.	
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	Physician		23a. Part . Enter the disease, o comp shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	е.		. 7.9			1004		Into On	proximate erval Betu set and E	veen Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	CONSEQU		enal f	ailure				40	day:	5
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68760,	rtificate be executed og physician and as the burial-transit	/edical		d										
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Division or Vital Records, P.O. Box	Attending Physician: The law requires that the death cer death. ector: After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal	death 3	Ectopic pregnanc Other (specify)	<i>y</i>			23d. Date of Month	delivery Day	y Y	ear/
ď.	s that med b e deta	by Pr	Part II. Other significant conditions of					en in Part I.	23e. Did to	obacco	use contribut	te to the ca	ause of d	eath?
ord	equire sen sig	ted t	Hyponatre	mia, H	4 po	myro	idism		1 🗆 \	Yes 2	No 3[] Probably	/ 4□\	Inknown
al Rec	ding Physician: The law n. After this certificate has be funeral director, page 2 sh	Completed							24a. Was autop perfo 1□ Yes		prior		etion of ca	available ause of
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10	g Phy er this eral di	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	у	28b. Time of			ome 5 Residence 128d. Describe h			Specify)		<u>.</u>
Sior	endin sath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident investigation		(Gai)	Injury		Yes 2 □ No						
N N	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	ry - At hor :. (Specify	me, farm, str	eet, factory, office		28f. Location (5 City or Tov	Street a vn, Stat	nd Number o e)	r Rural Ro	oute Num	ber,
_	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I		29a. Certifier 1 Certifying Ph	ysician: To the best o	of my knov	vledge, death	occurred at the ti	me, date and place,	and due to the	cause(s	s) and manne	er as state	d.	
	he Ho in 24 h he Fu pletely	edical	(Check only 2 Medical Exan	niner: On the basis of and manner sta	examinat	ion and/or in	vestigation, in my	opinion, death occur	rred at the time,	date ar	nd place, and	due to the	e cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	ii.			29c. Licens				ate signed (M			
	1		20. Name and address of access of	, MD	noth /lt	222\ /T	Print) C 115	53928	E (- LIA	A 4	5/18	1200		
	U		2434 W. BEL	VEDERE	AVE	BA	LTIMOR	E , MD -	- 21219	5				
0.	Sta Registr		30. Name and address of person who of 2434 W. BEL 31. Date filed (Month, Day, Year) MAY 2 1 20	32 . Registra	r's Signat	ure		·						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 5: 36 PM May 07 Elizabet /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Agnes 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 216-20-9317 Hours 1 □ M 2 F Months Days 01-06-1924 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No ltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. Completed by Funeral American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) lizabeth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Service Livensee 21229 22. Name and Address of Facility 5151 Baltimore Nat'l R'Ke, Baltimore, Mi sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. 23a. Part1. Enter the viseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) gram negotive bacteria in the blood days **Physician** /Medical Due to (or as a consequence of): Examiner intection days wound Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Completed by Physician/Medical Examiner metabolic The law requires that the death certificate be executed Severe attending physician a for use as the burial-Box 68760. IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the and be detached for 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 / No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performad? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural
2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P 20966 Eyad Alsheikh MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Baltimore, MD, 21279 3. Caton 900 Ave Eyad Alsheikh 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 2007 Registrar

			For				. Ensure All Health and M		•	e.
			State Registrar		Ce	rtificate of	Death		Reg. No.	7 16345
r	Physici	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Ye	3. Time of Death
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,	Examir	ner	4a. Facility Name (If not institution, give st. 5914 Franklin Av		Δ	4b. City, Town, o	or Location of Death		4c. County of I	Death
-	Funeral	6	5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year		8. Date of Bir	th 9.	Birthplace (State or Foreign
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	nd ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	action				Liou i os ii ii
	faryla shov	ō	MD NA		Baltimo					10d. Inside City Limits 1 X Yes 2 □ No
	the N 28a-1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
	3a or		5914 Franklin Av	e Apt 2	A		21207		U.S.	
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98	after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No. If Yes, Give	o	1 ☐ Yes 2 ☑ No		nicari, etc.)	Specify:	White, etc. Black
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ylar	2 should be to and Mental I is marked of raumatic eve	일	Haywood Hightowe	er			Frances			
Maryland 21215-0036	2 sho and is ma		19a. Informant's Name/Relationship (Type	,			and Number or Rura			
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Baltimore,	Pages nent of I ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	noval from State	20b. Place of Dispo cemetery, crea	matory or other pla	1			,
ij	ユキザラ		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	1	Metro	2. Name and Addre	5/19,	/07	Balto.	, Md.
ä	Depar Impor any ir		XYMMA CE	Guard		300 Waba	ash Ave,	Balti	more, Mo	21215
	Physician /Medical Examiner		reguling an dealiny	A - Lang	[[0 /	ng, such as cardiac o			Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.		consequence of):	7,18				
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<u> </u>	Attending Physician: The relath. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	spital:		oth Oth	26. Place of Death			
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Division	i je e	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur- building, etc.	y - At home, farm, str (Specify)	reet, factory, office	2	8f. Location (S City or Tow		r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	r: On the best of and manner state	examination and/or in	vestigation, in my	opinion, death occurre	and due to the ed at the time,	date and place, and	due to the cause(s)
)	with	2	29b. Signature and the oricertifier	Deputy)/8	667		29d. Date signed (N	
	6		30. Name and address of person who com	pleted cause of dea	ath (Item 23a) (Type,	PLID M. [CILuther	ما ان	MIN 21	,2007
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 13 Day **Physician** Iaru mai 200 /Medical Facility Name (III not institution, give street and number) 4c. County of Death or Location of Death Examiner not Maryland ; more If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 6-21-1947 5. Social Security Number 6. Se 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min. 1 M & F 215-46-9357 59 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ansit: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Directo MD NA Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? S 1109 W. Lombard Street 21223 Ũ Α Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B W I Airport Housekeeping 12th gràde 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Martin James Burgess ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 W. Lombard Street Balto, MD 21223 Leslie Hall-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: if ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donațion 5 ☐ Other (Specify) Western Star Cem 5-19-2007 Catonsville, MD 21. Signal re of Funeral Service Licen 22. Name and Address of Facility March West F/H 21215 MD 4300 Wabash Avenue Baltimore, 23a. Part1. Ehrer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician massive one hour resulting in death) /Medical Due to (or as a consequence of): Examiner Ulmonary Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit OI Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical use as signed by the attending to be detached for use as IF FFMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Brian Evene MD 110 S. Pow St. Sixth floor, suite 200 32. Registrar's Signature. 31. Date filed (Month, Day, Year) State DRUGE MAY 2 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 20b, perFH, G867, 5/21/07 TT Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day James Howard Hull 007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 49 +4 Baltimore Street Baltimore If Under 1 Year | If Under 24 Hrs. | Hours | Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1**X**M 2□F 515-28-7518 Uly 12, 193 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Maryland BaHiMore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 49th Street 21224 703 12. Was Decedent Ever in U.S. Armed Forces? LEXYes 2 □ No If Yes, Give Year or Dates: ≺ oce A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) arpenter 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Armstrong HUI Jahn Clara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 49th Street MD. 703 21224 Margaret 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/22/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Hanover, MD Gifts Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P. Hansver, MA 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Netastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Funeral Director

Be Completed by

၉

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box $68760^{28}_{
m c}$

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 □Ectopi	icpregnancy (specify)		23d. Date of delive Month	ry Day Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlyin	ng cause given in Part I.	23e. Did tobacc	co use contribute to th	
				24a. Was an autopsy performed 1∐ Yes 2	? death?	osy findings available npletion of cause of 2 ☐ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 Residence	e 6 □Other (Specify	()
27. laver of Death atural 5 Pending 2 Accident investigati		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
3 ☐ Suicide 6 ☐ Could not determine		nome, farm, street, fac ify)	ctory, office	28f. Location (Street City or Town, St	t and Number or Rural tate)	l Route Number,
29a. Certifier (Check only one) 1 Certifying F	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death occur action and/or investiga	red at the time, date and plaction, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month, I	Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2

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cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔒 🗎 🧻 1- For State Amend #29c, perDVR, G867, 5/21/07 TI Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) May 14, 2007 **Physician** 12:12 PMM Carl Andrew Heselbach /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Garrett Garrett County Memorial Hosptial Oakland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Jan 10, 19 Birthplace (State or Foreign Country) **Funeral** Hours Days 1 M 2 □ F 74 213-33-8655 1933 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other then "neturel", or items 23a or 28e-1 show eny injury or other treumatic event, the Maryland Exercite. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Garrett 1 ☐ Yes 2√ No ğ Swanton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 199 Piney Point Road 21561 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □ No
If Yes, Give
Year or Dates: 150-54 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white ₹ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Norwood Andrew Heselbach Leavinia Mary McLewee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Heselbach/spouse 199 Piney Point Drive Swanton, MD 21561 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner 4096 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificete 2 X No 1 Yes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗆 Yes 2 No 1 Hopatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

MAY 2 1 2007

31. Date filed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

D23979

5,14,7

			For State Registrar	State of Marylan		nt of Health and te of Death		ene 0 7	16349
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last, Vyletta Hair 4a. Fatility Name (If not institution, give		4b. Cin	, Town, or Location of De	2. Date of Death Month May	Day Year 12 2007 4c. County of Death	3. Time of Death 5: 40 AM
	Funeral Director	lei	Maryland Czene 5. Social Security Number 6. Se.	ral HOSPito 7. Age Vin yrs.	U Ba	timero C	rs. B. Date of Birth	Year) 9. Birth	place (State or Foreign intry)
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location	nare			10d. Inside City Limits 1 No 2 No
	ath with the 23a or 28 ust be not	ral Direc	10e. Street and Number 422 Orchard 5	reet Apt#1		21201	10	g. Citizen of What Cou	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show appropriately from the traumatic event, the Medical Examinat must be notified at angle.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Deor If Yes, spi	edent of Hispanic Origin? ecify Cuban, Mexican, Pu 2 No Specity:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: B	
21215-0036	id within 72 h giene. er then "natu	Sompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of v	vorking 1	6b. Kind of Business/li	,
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-	is 1 and 2 sh of Health and item 27 ie m other traum		19a. Informant's Name/Relationship (Ty	1 sister	502 De	s (Street and Number or	ad	City or Town, State, Zi	p Code)
Baltimore	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Place of Disposition (National Place)	other place)	دا مید	Oc. Location - City or T	
Balti	permit. Departrimports any inju		21. Signature of Funeral Service Licens	999	22. Name a	and Address of Facility V	()	une funeral	
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	cations that caused the deather cause on each line.	h. Do not enter the mo	de of dying, such as card			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	ACQUICO	uence of): Immune	Deficienc	y Syndr	one	
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Records, P	The law requires that the site has been signed by the page 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I.		acco use contribute to 2 □ No 3 □ Pro	the cause of death?
I Rec	The law released the page 2 sh	Completed					24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of 2☐ No
Vita	ician: certific ector.	Be	25. Was case referred to medical examiner?	ospital:		Other	eath (Check only one		
Division of Vital	To the Hospitel or Attending Physician: The I within 24 Hours eiter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	atlon: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 D 28b. Time of Injury M	OA Cther: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	Home 5 Residen	ce 6 Other (Speci v injury occurred	fy)
Divis	el or Atte s efter de: il Directo id in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, facto	ry, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	Hospit 24 hours Funere letely fille	Medical C	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Exemi	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	d at the time, date and plan, in my opinion, death oc	ce, and due to the cau curred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
1	To th within To th comp	Me	29b. Signature and title of certifier	4	1 14	C. License number		d. Date signed (Month,	
	2		30. Name and address of person who co	mpleted cause if death (Item	1 23a) (Type, Print)	89579 aryland G	i 1	may 12.	2001
	Sta	te	31. Date filed (Month, Day, Year)	1+ har ay our 32. Registrat's Signa	ture ture	aryland G	eneral t	tespital	
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07-03737	
Dronda Harria	

Brenda Harris	State of Maryland / Department of Health and Mental H 1- For State Certificate of Death Registrar	lygiene Reg.	No. 200	7 16351
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Brenda Harris	2. Date of Death Month D May 16, 200	Day Year 07	3. Time of Death 0920 hrs
,	4a. Facility Name (if not institution, give street and number) Mercy Hospital 4b. City, Town, or Location of Death Baltimore	h	4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr: Months Days Hours Mir		(MM/DD/YYYY) 9. Bin Foreig Co	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		+0 1	10d. Inside City Limits
	MD Baltimore 10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	1 X Yes 2 No
vith the Mi s 23a or 21 e notified	1125 Webb Ct. 21202 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Amer	can Indian, Black,
Rer death with I", or items 23 er must be no / Funeral	Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 No specify:	o Rican, etc.)	White, etc. Specify: Black	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene Irant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Control of the complete of		6b. Kind of Business/	
5-0036 ed within 72 hour. yygiene other than "natu the Medical Exan Completed	,,	ne (First, Middle, Ma	Domestic diden Surname)	
2121 total be fill d Mental Is s marked tic event,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		-	, Zip Code)
re, MC stand 2 st f Health an If item 27 i	Hishon Smith / Daughter 3466 Barkley Woods Rd. Win 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State crematory or other place)		MD 21244 20c. Location - City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Menial Hygene Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple	4 Donation 5 Other Specify: Metro Crematory 05/1		Catonsville,	
한 환경 토記 Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	•		Approximate Interval Between Onset and
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'60, ate be execut physician and he burial - tra	X UNPENDED AMENDED 7,28a-f perME, g867, 5/29/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	у
D. Box 6876(The death certificate by the attending phy sched for use as the Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregress 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	nancy	Month	Day Year
P.O. E es that the igned by the be detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death? bably 4 Unknown
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed its after death. al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit ertification: To Be Completed by Physician/Medical Exertification: To Be Completed by Physician/Medical Exertification:		24a. Was an autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of es 2 No
ital Rician: Tital Rician: Tital Ricetor, p	25. Was case referred to medical examiner? Hospital: Inpatient 2 ✓ ER/Outpatient 3 DOA Other Wars Nurs		tesidence 6 Othe	r
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Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page ledical Certification: To Be Con	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) residence 17 Could not be determined (Specify) residence	or Town, Sta		ural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in Medical Certific	4 Homicide	nd due to the cause	(s) and manner as sta	ted.
To cor	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	onth, Day, Year)
7	30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201		
State Registrar	31. Date filed (Month, Day, Year) MAY 2 1 2007 32. Restrar's Signature			

2007 16351

Maurice Alfred Jo		State of Maryland / Department of Health and Mortal For State Certificate of Death	Reg. No).	
() voicio	Re	gistrar 2. E	Date of Death Month Day	Year	3. Time of Death 0300 hrs
nysicia Met £xamir	11/	Marine Altred Johnson	1ay 18, 2007	c. County of De	
	4:	Facility Name (if not institution, give street and number) 4b. City, Town, or Eccation of Beauty The street and number is a street and number.		Baltimore C	
		Northwest Hospital Certier	. Date of Birth(Mi	WDD/YYYY) g.	Birthplace (State or
Funeral	5	Social Security Number 6. Sex 7. Age (III yis. last bittiday) Months Days Hours Min.	JUNE 121		eign Country) MARY And
Director	d	2/2-94-8858 1XM 2 F 27 Yrs.	1018 12,1	7././	
Š.		sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
ow any	1	L. Parlinge Randollstown			
yland a-f sh	힣	On Street and Number 10f. Zip Code	10g. (Citizen of What C	Country?
death with the Maryland or items 23a or 28a-f show must he notified at once.	Director	1113 Tueffun Ciècle 2/133			merican Indian, Black,
with the s 23a s 23a	틸	1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Special Status) 14. Was Decedent of Hispanic Origin? (Special Status) 15. Was Decedent of Hispanic Origin? (Special Status)	ify Yes or No- can, etc.)	14. Race - Ar White, et	
leath r		1 Never Married 2 Married 1 Yes 2 No		Specify: A	FICAN AMERICAN
after call, o	by F	3 Wildowed 4 Divorced or Dates:		b. Kind of Busine	
nours natur	ed	during most of working life. DO NOT use retired	1)	T 1	SHOPPERS
36 in 72 l han "	plet	Shopes Ocenight	Stocker	tood	310RC
5-0036 led within Hygiene. I other that	Completed	17 Fether's Name (First, Middle, Last)		ien Surname)	
215 be filed ntal Hy rked of	Be	John Johnson Johnson	, ,,	-	State, Zip Code)
2121 ould be f d Mental s market		198. Informatics Nation Control of the Control of t		nills MA	eyland 21117
MD dd 2 shot lith and m 27 is		John Erick State Charactery	Date 2	0c. Location - Ci	ty or Town, State
te lea	1	20a. Method of Disposition 3 Removal from State crematory or other place)	25,2007	ams/lon	W MARyland
Pager Pager ment o		4 Donation 5 Other Specify: Rung / Penaral Pray		ervice	, , , , , , , , , , , , , , , , , , , ,
Baltimore, pernit. Pages 1 at Department of He Important: If ite injury or other It	:\ [21. Signature of Fulletin Street	- Baltin	nore, man	eyland 21229
	_	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arrest	, shock, or heart	Between Onset and
/siciar /Medica		failure. Listonly one cause on each line.			Death
Examine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	iner	if any, leading to immediate Due to (or as a consequence or).	F) 1		
1	Examine	(Disease or injury that initiated events resulting in death) Last			
executed an and transit	l û	d			
(0), control of the executed sysician and busing transmission.	ledical	UNPENDED		23d. Date of o	lelivery
760 icate b	We Di	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregna	ncy	Month	Day Year
68 certiff	cian	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Box 6876 e death certificat	ched for use as the Physician/N	1 Yes 2 No 9 Unknown g Unknown	23e. Did to	acco use contrib	oute to the cause of death?
P.O. I set that the gned by t	etache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes	2 No 3	Probably 4 Unknown
S, P	d be det		24a. Was a		Vere autopsy findings available rior to completion of cause of
ords w requ	age 2 should be		autops	med? d	eath?
ecc The far	age 2	26 Place of Death (Check	1 Yes 2	No	Yes 2 No
al R an: T ertific	ector, p	25. Was case referred to medical		Residence 6	Other:
Division of Vital Records, tall or Attending Physician: The law requirers after death. "In Director: After this certificate has been s	al dire	1 Ves 2 No Inpatient 2 Person Figury 28b, Time of Injury 28c, Injury at Work?	28d. Describe	now injury occurr	ed
n of ing P	funera	27. Manner of Death	Subject was		
sior attend death ctor:	y the	2 Accident May 18, 2007 0034 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			er or Rural Route Number, Cit
ivis lor A after	filled in by the fune	3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.	3422 Barry Pa	ul Road, Apt.	102, Randallstown, MD
C ospita	ly fill		d due to the caus	e(s) and manner	r as stated. tue to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Functor: After this certificate has been signed by the attending physician.	completel	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date		ned (Month, Day, Year)
To	COL	29c. License number		May 19, 20	led (Month, Day, rear)
_		hy hi, mis		Iviay 19, 20	
		30. Name and address of person who completed cause of death (Item 23a)			
(9	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, Nib 21201			
	Sta	AVIZIT / I / I III /			
Re	gistra	HILL W TO WOOD			

				State of Marylan	d / Depa		lealth and M	ental Hygi	•	16352
1	Physici /Medic		1. Decedent's Name (First, Middle, Last) Kathy D. Jones					2. Date of Death Month MAY	Day Year	3. Time of Death 2. 7:344 M
	Examin		4a. Facility Name (If not institution, give stre	,	·TER	BAZ	r Location of Death		4c. County of Dea	ith
	Funeral Director		5. Social Security Number 219-80-2764 Usual Residence of Decedent	7. Age (In yrs. 46	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 28,	9. Bin C 1960 Ma	rthplace (State or Foreign ountry) cryland
	Maryland a-f show iffed at	tor	10a. State 10b. County MD	10c. Cit	y, Town or Lo					10d. Inside City Limits 1√2 Yes 2 ☐ No
	th with the 23a or 28	al Director	10e. Street and Number 1202 N. Washington	Street		10f. Zip Code	1213	10	g. Citizen of What C USA	ountry?
036	72 hours after death with the Maryland 'naturel', or items 23a or 28a-f show Jical Examinat must be notified at	by Funeral	11. Marital Status 12. 1 X Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	İ	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 21 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	within ane. than	Completed	15. Decedent's Educat (Specify only highest grade c Elementary/Secondary (0-12) unk unk	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Lsabled	ation during most of workir d)	ng	6b. Kind of Business	/Industry
Maryland 2	should be filad nd Mental Hygid i marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Deamous Jones					(First, Middle, M Johnson		
	alth ar 11th ar 27 is r treu		19a. Informant's Name/Relationship (Type, Nathaniel Jones/bro	ther	3108	E. Monum	and Number or Rura nent Stree	t Baltim	ore, MD	21205
Baltimore,	Page: nt: ff ry or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 ☒ Other (Specify)	n state	emetery, crer	sition (Name of natory or other plac	ca)		Oc. Location - City or	
Bal	permit. Depart Import any inji		21. Signatur Funera Service Licensee RON Id Wa	Man/	Ra	Itimora	ss of Facility Omy Board MD 21201			1
	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, of compilea shock, or heart failure. List only one disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Under this Cause (Disease or Injury that initiated events c.	Due to (or as a conseq	uence of):		R. CAN		26,	Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
.O. Box	death certi e attending d for usa a	Physician/Med	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	olivery Day Year
rds, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contri	outing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		acco use contribute t	o the cause of death?
al Record		Completed							ed prior to death?	utopsy findings available completion of cause of s 2 No
ion of Vital	ling Physicions. After this certioneral direct	atlon; To Be	1 162 2 2 100	pital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	y at 2		nce 6 Other (Spe	ncify)
Division	itel or Attend ins after death rel Director: , led in by the f	Certification:	4 Homicide	28e. Place of Injury - At ho building, etc. <i>(Specif</i>	y) 			City or Town,		
	To the Hospitel or vaithin 24 hours after To the Funerel Directorpletely filled in b	Medical	one)	an: To the best of my kno : On the basis of examina and manner stated.	wledge, death tion and/or in	estigation, in my o	pinion, death occurre	ed at the time, da	te and place, and du	e to the cause(s)
	Nith To			REDICAL AT		29c. Licens		-	d. Date signed (Mon	
	<u>.</u>			eleted cause of death (Iten	23a) (Type,	Print) DR	0600 39. MAN: N BATIM	- 00, M	(1)	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 1 2007	Registrar's Signa	lure	B				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year MA TG145 Ansen 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUMMIT PARK HEALTH CatomsvillE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 12 M 2 ☐ F 9. Birthplace (State or Foreign Country)
ALIARAMA 1297 80 421 26 OCT 12 1926 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No BALTIMORE Catonsville mo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code REDERICK ROCK 21228 USA 1502 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗡 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES MANAGER

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

Director Funerai þ

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural", or itema 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Completed

Be

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

s certificate has the director, page 2 s

Division of Vital Records, P.O. Box 68760,

0	MATHIAS J.	JANSEN, SR	41	SARIL	OA FOST	ER	
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address	(Street and Number or Re	ural Route Number, City	or Town, State,	Zip Code)
	DARLENE REIDY,	DAUGHTER	2100 ARRI	NGTON ROA	O MARRIOT	TSVILLE,	mo 21104
	20a. Method of Disposition		Place of Disposition (Nan cemetery, crematory or of	ne of		Location - City or	
	1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	JHemovai from State	th CARWII C	nem 5/1	9/2007 W	NFICLE	i, mo
	21. Signature of Funeral Service Licer	mbun	102000000000000000000000000000000000000	Address of Facility J			The second secon
	23a. Par violer the disease, or com slock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not enter the mode	of dying, such as cardia			Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	quence of):	seay			
miner	Sequentially list conditions, I are leaving to time out cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):				
Icai Exa	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
nysician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6 9 Unknown	al death 3 Ectopic pre			23d. Date of de Month	slivery Day Year
ed by P	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying ca	iuse given in Part I.		use contribute t	o the cause of death?
omplet					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
26	25. Was case referred to medical examiner?		-	26. Place of Dea	ath (Check only one)		
0	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	A Other: Nursing H	lome 5 Residence	6 ☐Other (Spe	ecify)
ation:	27. Manner of Death 1 Satural 5 Pending 2 Accident investigation		28b. Time of Injury M	Bc. Injury at Work? 1 Yes 2 No	28d. Describe how inj	ury occurred	
Certific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory	office	28f. Location (Street a City or Town, Sta	and Number or Rite)	ural Route Number,
dical	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knoniner: On the basis of examination and manner stated.	owledge death occurred ation and/or investigation,	t the time, data and plane in my opinion, death occu	and due to the cause, urred at the time, date a	s) and manner and place, and du	t stated e to the cause(s)
Me	29b. Signature and title of certifier	200a	290.	License number	29d. D	ate signed (Mon	th, Day, Year)
	30. Na, e and address of person who	completed cause of death (Item	m 23a) (Type, Print)	Rouski	-tour 1	Manda	12121
e	31. Date filed (Month, Day, Year)	32. Renistrar's Signa	ature			1	7.36
	MAY 1 9 2	007 Leene	H. Local				
1			1				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Kratochvil Sr. P^{M} May 16,2007 1:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 9,1916 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1XM 2□ F 219-03-2672 90 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Dundalk 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6711 Gary Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9 years Maintenance General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen Kratochvil Helen Orlick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Kratochvil wife 6711 Gray Avenue, Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation Sacred Heart Of Jesus Cem. May 19,2007 Dundalk, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADENO CARCINOMA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

g physician a attending p ate has been signed by the atte page 2 should be detached for Records, P.O. Vital 0

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

marked other than matic event, the Me

permit. Pages 1
Department of H
Important: If iter
any Injury or oth

Physician

/Medical

Examiner

Physician/Medical

þ

Completed

Be 2

Certification:

Medical

State

Registrar

Funeral

δ

Completed

Be

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

23b.	MALE: Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oic pregnancy r (specify)		23d. Date of delivery Month Day	Year
Part I	I. Other significant conditions of	ontributing to death but not resulting in the underlyi	ng cause given in Part I.		o use contribute to the ca	
				24a. Was an autopsy performed? 1 ☐ Yes 2 🔣		
	las case referred to medical xaminer?		26. Place of Deat	h (Check only one)		
	Yes 21X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Ho	me 5 Residence	6 X Other (Specify)	IOSPTCE
1	lanner of Death INatural 5 ☐ Pending ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		28d. Describe how in		IODI TOL
	☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street City or Town, Sta	and Number or Rural Rol ate)	ate Number,
29a.	Certifier (Check only one) Certifying Ph	ysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investiga and manner stated.	rred at the time, date and place, ation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated and place, and due to the	cause(s)
29b.	Signature and title of certifier	>-	29c. License number	29d. [Date signed (Month, Day, 5/16/07	Year)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

COAL S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

MAY 2 1 2007

31. Date filed (Month, Day, Year)

			For State Registrar	State of	Maryland / De	epartment of Certificate o			glene Reg. No. 0 7	16355
	Ohoois	(m	1. Decedent's Name (First, Midd	lle, Last)				2. Date of De Month	ath	3. Time of Death
B	Physic /Medi		Clarice	Kemp				May 15	•	5:25pm ^M
	Exami	ner	4a. Facility Name (If not institution	on, give street and numb	ber)	4b. City, Towr	n, or Location of De	ath	4c. County of Death	
	جنوب بد حدث	V	Larkin Chase 5. Social Security Number		me . Age (In yrs. last birth	Bowie		rs. 8. Date of Bin	Prince G	
В	Funeral Director		578-09-7114	1□ M 2√2 F	100 Yr	Months Day		n. (Month, Da	y, Year) 9. Birth	place (State or Foreign intry)
			Usual Residence of Decedent	11_				April A	26, 1907King	ston, Jamaic
	anylan show	_	10a. State 10b. Count		10c. City, Town of					10d. Inside City Limits
	ne Ma 8a-f s	Director		e Georges	Suit1a					1 ☑ Yes 2 ☐ No
	23a or 2 ust be n		10e. Street and Number 3803 Swann Ro	ad #201		10f. Zip Code 207	9 746		10g. Citizen of What Cou United Sta	
900	o 72 hours after death with the Maryland "natural", or items 23a or 28a-f show sidical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried Armed Force	2 23 No	13. Was Decedent of If Yes, specify C 1 ☐ Yes 2 15 N		(Specify Yes or No erto Rican, etc.)	, , , , , , , , , , , , , , , , , , , ,	
1215-0	within 72 h ene. than "natu he Medical	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12) 1.2	nt's Education est grade completed) College (1-4	for 5+)	ecedent's Usual Occ Give kind of work do fe. DO NOT use ret ecretary	cupation ne during most of и ired)	vorking	16b. Kind of Business/In	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho to f Heath and Mental Hygiene. If Item 27 Is marked other than "natu or other traumatic event, the Medical	To Be Co	17. Father's Name (First, Middle James Herron	, Last)		ceretary	18. Mother's N Marga		Maiden Surname) IN	
ary	shou and N s mar		19a. Informant's Name/Relation	ship (Type. Print)	19b. N	lailing Address (Stre	eet and Number or	Rural Route Numbe	er, City or Town, State, Zip	p Code)
	and 2 ealth n 27 I		Teddi Campbel	1-Cooper	450	Q. Stree	t N.W. W	ashington	D.C. 2000	01
Baltimore,	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Removal from St	cemetery,	isposition (Name of crematory or other p livet	olace) ;	Date 22,2007	20c. Location - City or To Washington,	
Balti	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau		21. Signature of Funeral Service	Linksee	orass	22. Name and Add 5538 Ma	dress of Facility of Port Port Port Port Port Port Port Port	pe P.A. ikė/Fores	tville, Md.	20747
8760,	Physician // Medical Examiner physician and physician and the priviler-transit physician site physician are physician and physician are physician and physician are physic	dical Examiner	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pue to (or Due to (or c.	as a consequence of) as a consequence of)	tony Sostn	dying, such as card	ac or respiratory and according to the second secon		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificat the has been signed by the attending phyage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 9 □ Unknown	1 ☐ Live birt	ome pf pregnancy h 2 □ Fetal death nt at time of death nn	3 □Ectopic pregnal 5 □ Other (specify)			23d. Date of delive	ery Day Year
	requires that een signed by rould be deta		Part II. Other significant condit	ions contributing to deat	th but not resulting in the	e underlying cause	given in Part I	23e. Did to	obacco use contribute to ti	he cause of death?
Division or Vital Records,	2 38 2	Completed by					1			opsy findings available impletion of cause of 2 No
Vit	Physician: this certificanal director,	Be	25. Was case referred to medica examiner?	Hospital:				eath (Check only o		
ō	Phys r this ral di	- L	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of		ment 3 DOA	4/CHNursing		lence 6 Other (Specificon injury occurred	ý)
O	Attending Frdeath. ector: After	tion	1 Natural 5 ☐ Pendi		Day Year) Inju	ry W	ijury at/ Vork? □ Yes 2 □ No	Edd. Boombo (iow injuly occurred	
Divisi	I or Attendl after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could determ	not be 28e. Place of	finjury - At home, farm , etc. <i>(Specify)</i>			28f. Location (S City or Tow	Street and Number or Rura In, State)	al Route Number,
_	To the Hospital or Attending Physician: The within 24 burns after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Co	29a. Certifier 1 ☑ Certifyi (Check only one) 2 ☐ Medical	ng Physician: To the be Examiner: On the bas and manne	is of examination and/o	eath occurred at the rinvestigation, in m	e time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as s	tated. o the cause(s)
	To the within :	Me	29b. Signature and title of certific			7 29c. Lice	ense number		29d. Date signed (Month,	Day, Year)
	0		1	~/		() c	3452	-17	I/IL(~)	,
/	7		30. Name and address of person	who completed cause	of death (Item 23a) (Ty	pe, Print)			711919	
	(ayi M.D. 6	201 Greenb	elt Rd. S	-U15 Col	lege Park	, Md. 20740	
	Sta Registr		31. Date filed (Month, Day, Year,	2007 32 . Reg	istrar's Signature	ede				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2007 John A. Kimball Jr May 10, 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 532 Ferry Point Road Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Ye)
Jan 17, 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□ F 87 ĬŸ20 Maryland Director 220-01-4743 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County rithen "naturel", or terms 23a or 28a-f ehow the Madical Examiner must be nutified at 10d, Inside City Limits MD Anne Arundel Annapolis 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 Ferry Point Road 21403 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: if item 27 is marked other ti
eny injury or other traumatic event, the technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Arthur Kimball Louise Agnes Stehle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Kimball/spouse 532 Ferry point Road Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signatur of uneral Service Licensee Ronald S. Warde Director Baltimore, MD 21201 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part Enter the disease, or complications that shock or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ata has been signed by tha page 2 should be detached Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 Yes 2 No 1□ Yes 2€ No the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29a. Certifier Medicai 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) mul completed cause of death (Item 23a) (Type, Print) HGHWAN, NNAPULISMA ZIXUI ICHARIJLGENTA IM 445 DEYENSE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

ORIGINAL

		_ 1	For State Registrar	State of M	laryland / I		irtment of H tificate of L			iene _{eg. N} 2 0 0	17	16357
4	Physicia		I. Decedent's Name (First, Middle,	Lasi) KENNE) y				2. Date of Dea Month May 9,	28 8 7	Year	3. Time of Death 8:05 PM M
	/Medic Examin		la. Facility Name (If not institution, Future Care	give street and number			4b. City, Town, or Baltimo			4c. County	of Death	
	Funeral Director				ge (In yrs. last bi 75	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 27	, 1931	Coui	olace (State or Foreign ntry) ginia
	e Maryland 8a-1 show		Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Tov		more			10g. Citizen of V		10d. Inside City Limits 1 Yes 2 No
	th with th	al Dire	10e. Street and Number 2518 N. Calver	t Street #1				1218		U:	SA	
920	urs after dea al', or Itams	by Fun	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces at 1 Yes 2 2 If Yes, Give Year or Dates	2 ∮No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🎇 No	spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	Blac	e - Amen k, White, : whi	_
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event. It is Moureal Examination unit be notified at anone.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4o		(Give life.	dent's Usual Occupi kind of work done o DO NOT use retired tress	furing most of wor	king	16b. Kind of Bu		·
and 2	id be filed ental Hygi kad othar ic evant, I	To Be Co	17. Father's Name (First, Middle, L Samuel Hugh H						ne <i>(First, Middl</i> e, Ly May W		10)	
Maryland	d 2 shoul th and Me 17 ia mark traumati	F	19a. Informant's Name/Relationsh	_	19		ng Address (Street :					p Code) 21218
Baltimore,	Pages 1 an lent of Heal nt: If itam 2 ry or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from Stat		of Dispo	osition (Name of matory or other place	8)	Date	20c. Location -	City or T	own, State
Balti	permit. Departm Importa any inju		Humm 1	Way, Din		Ba	Name and Addre ate Anato altimore,	MD 2120	01		ore S	Street
8760,	death certificate be executed Wedical Examine A for use as the burial-transit A for use as the burial-transit	edical Examiner	23a. Patt1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or a Due to (as a consequence	he of): Zen e of):	nt fail	me eose				Interval Between Onset and Death
.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \)		2 Fetal dea at time of death		□Ectopic pregnancy □ Other (specify) _	1			te of deliventh	very Day Year
Δ.	uires that t signed by Id be deta	by	Part II. Other significant condition	ons contributing to death	n but not resulting	jin the u	underlying cause gr	en in Part I.				the cause of death?
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed	24a								. Was an autopsy performed? Yes 2 \(\textstyle \) No	
	yaician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	atient 2 ER/	Outpatie	nt 3 DOA	or /	ath <i>(Check only c</i> Home 5 ☐ Resi		ner <i>(Spec</i>	orfy)
ion of	Jing After fune	ation; T	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	9	njury 28b Day Year)	. Time o	Wo		28d. Describe	how injury occur	rred	
Division	al or Attandi s after death. I Diractor: A id in by the fu	Certification;	3 Suicide 6 Could determ	inod 286, Place of	Injury - At home, etc. (Specify)	farm, si	treet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edical (29a. Certifier 1 (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basis and manner	s of examination	dge, dea and/or in	th occurred at the tinvestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifie	Que land	i		29c. Licen:	フェフ		29d. Date signo	12-	-07
			30. Name and address of person DALSHAN 31. Date filed (Month, Day, Year)	who completed cause of	death (Item 23)	a) (Type	MOUNT	Royal 1	tre, Da	lto M!) 2	1217
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2007 32 neg	istrar's Signature	4	relie					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MAY. 9:05AM Stevie Little 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GEN ESIS CENTER Honowood BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Dec 6, 224-04-8213 Director 46 Mary1and Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "naturel", or items 23e or 28e-f showing the Modical Examiner must be notified at 1 Yes 2 No Funeral Director MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 6000 Bellona Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: black 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) home improvements 12 ith and Mental Hygie 27 is marked other i r treumatic event, II unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H ent: If item 27 is marked ott Mary Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyra Little/daughter 1359 Deanwood Road Baltimore, MD 21234 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō `4□Donation 5፟፟፟XOther (Specify) in state 21. Signature of Europeal Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. P.rt1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE iv /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physiclen: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy for detached s been signed by the should be detached has

Be Completed the funeral director, page 2 Medical Certification: To this after death

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

in the past 12 months? 1 Yes 2 No 9 Unknown		ctopic pregnancy Other (s <i>pecify)</i>	Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the und	lerlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Death	Check only one
1 Yes 2 No	Hospitaf: 1 Inpatient 2 ER/Outpatient	3 DOA Other: Nursing Hor	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigati		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Coufd not determine		et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying F (Check only one)	hysician: To the best of my knowledge, death of miner: On the basis of examination and/or inve	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause(s) and manner as stated. and at the time, date and place, and due to the cause(s)

completed cause of death (Item 23a) (Type, Print) Dr MAW NAING CO, MD

D0062239

29d. Date signed (Month, Day, Year)

11 2007.

MAY

BALTIMORO

State Registrar

filled in by

completely

To the

MAY 2 1 2007

Honewood

29b. Signature and title of certifie

30. Name and address of person w

31. Date filed (Month, Day, Year)

PHYSICIAN

THOMAS CANGAN 5/18/07 0200 AM

			Please	Type or Prin					-		_egible.	
			1 - For State Registrar	State of Ma	aryland		partment of H ertificate of I		Mental Hy	giene		
(8)			Registrar 1. Decedent's Name (First, Middle, La	ist)			ertilicate of t	Dealn	2. Date of De	Reg. No.	2007	3. Time of Death
	Physicia /Medic		Thomas J. Langan						Month May 18	Day	Year 7	2:00 A. M
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	r Location of Death		1	County of Deat	
	-		Suburban Hospital				Bethesda				ntgomer	*
	Funeral Director		5. Social Security Number 6. \$ 577-50-1259	Sex 7.Ag 1⊠M 2□F	e (In yrs. la	ast birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D		Co	hplace (State or Foreign buntry)
41			Usual Residence of Decedent		73				Jan. 6	, 193	4 Peni	nsylvania
	arylan show dat	_	10a. State 10b. County		10c. City	, Town or l	ocation					10d. Inside City Limits
	he Ma 28a-f	ecto	Maryland Montgome	ry	Beth	esda						1 ☐ Yes 2 ☑ No
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	لمما			10f. Zip Code				en of What Co	,
	death ms 2:	nera	5505 Northfield F 11. Marital Status	12. Was Decedent		3. 13	20817 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or N		ed Stat 4. Race - Ame	rican Indian,
٥	after or Ite	/ Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ I If Yes, Give	No		1 ☐ Yes 2 ☒ No	an, Mexican, Puerto Specify:	o Rican, etc.)		Black, White	e, etc.
2-003b	hours ural"; Il Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	Kore			. ,				nite
<u>γ</u>	n 72 n "nat ledica	olete	15. Decedent's E (Specify only highest gra	ade completed)		16a. Dec (Giv life.	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of worl d)	king	16b. Kir	nd of Business/	Industry
7	d with giene. r thar the N	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ciate Prof			Nava	al Acad	emy
and	al Hyg	BeC	17. Father's Name (First, Middle, Last	")				18. Mother's Nam	,	•		-
Z Z	ould b Ment arked aric e	2	Eugene F. Langan					Elizabet	h T. 0	Keef	ē	
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship			1	ling Address (Street					•
a) 	1 and Healt em 2		Margaret M. Langa 20a. Method of Disposition	n / Wife	20b. Pl		Northfiel cosition (Name of rematory or other place		Betheso Date	· ·	aryland	
Saurimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or Items Z3a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				ematory or other place Crematorium	Tiay	21, 2007		•	aryland
	mit. F sartm sortar r Injur		21. Signature of Funeral Service Live		r.s.Jite		22. Name and Addres	ss of Facility				
Ď	permi Depa Impo any It	4	7.5.	70	M008	396 7	bert A. Pum 557 Wiscor	phrey Funer isin Ave.	al Home/l , Bethe	Bethes sda,	da-Chevy MD 208	Chase, Inc. 14-3501
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death	. Do not e	nter the mode of dyin	ig, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Anoxic	Encep	ha1o	pathy					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		,						·
	19	ē	Sequentially list conditions,	b. Coronar			isease					years
	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Hyperte	nsion	Hea:	rt Disease	<u>.</u>				vears
Ď,	e exection and and and and and and and and and an	Ex	resulting in death) Last	Due to (or as	a consequ	ence of):						<i>y</i>
00/0	leath certificate be executed attending physician and for use as the burial-transit	dica		▲d								
o X	certific	Physician/Medica	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv						
DO .	death atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal	death 3	☐Ectopic pregnancy	<u>'</u>			3d. Date of del Month	Day Year
S	t the c by the	hysi	9 Unknown	9□Unknown			, , _					
, L	The law requires that the death the has been signed by the atter bage 2 should be detached for u	by P	Part II. Other significant conditions of Mitral Valve Dise		ut not resul	Iting in the	underlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
cords,	w require			ase					10	Yes 2	No 3∏ Pr	obably 4 Unknown
i i	e law has b je 2 st	Completed	Diabetes Mellitus	· · · · · · · · · · · · · · · · · · ·					24a. Was	psy	prior to	topsy findings available completion of cause of
	n: Th ficate rr, pag		OF Man annu referred to modical						1□ Yes	órmed? 2⊠No	death? 1 ☐ Yes	2 No
5	/sicla	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2□E	-B/Outpatie	ent 3 DOA Othe	26. Place of Dea er: 4 ☐ Nursing H			Понь /О	-16.3
5	ig Phy ter thi neral c	\vdash	27. Manner of Death	28a. Date of Inju	iry	28b. Time Injury	of 28c. Injur		28d. Describe			city)
5	endin sath, or: Af he fur	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	, , , , ,	,,		Yes 2 □ No				
Š	or Att fter de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At hor c. <i>(Specify,</i>	me, farm, s	street, factory, office		28f. Location City or To	(Street and wn, State)	Number or Ru	ural Route Number,
	pltai	S	29a. Certifier 1 ☐ Certifying Pl	ny s ician: To the best	of my know	vledae dea	ath occurred at the tin	me date and place	and due to the	(a) cause (s)	and manner of	stated
	To the Hospital or Attending Physician: The law within 24 burus after death, To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	edical	(Check only 2 Medical Exa	miner: On the basis o and manner sta	f examinati	ion and/or	investigation, in my o	pinion, death occu	rred at the time	, date and	place, and due	e to the cause(s)
	To the Tour Comp	M	29b. Signature and title of certifier	1/			29c. License			29d. Date	e signed (Mont	h, Day, Year)
			- Timily	Kluns	NA	1.11.	86	019		May	18,2	zo 7
6	12		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type	e, Print)	siel bo	10,45	Lisin	chin	- Mont 1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Sign <i>a</i> t	ure	VI WON	יטון- טוינ	70	-654	1 -200	20815
	Registr	ar	MAY 2 1	2007	18.1	Elle A	back					
	41 1 7 Day 4/00			1	4	6	-					

	4	State of Maryland / Dep	partment of Health and Martificate of Death	
Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Last) VIRGINIA H. MARTIN 4a. Facility Name (If not institution, give street and number) MANOR CARE ROLAND PARK	4b. City, Town, or Location of Death	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 89 Yrs. Usual Residence of Decedent	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign Country) NEW YORK
the Maryland 28a-f show	ctor	10a. State		10d. Inside City Limits 1 ★ Yes 2 No 10g. Citizen of What Country?
ges 1 and 2 should be filed within 72 hours after death with the Maryland tost 1 and 2 should be filed within 72 hours after death with the Maryland if it iam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant, the Madical Exercit at Invit be notified at	ra	4669 FALLS RD	21209 Was Decedent of Hispanic Origin? (Sriff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	USA
of 2 should be filled within 72 hours aft that and Mental Hygiene. 77 Is marked other than "natural", or traumatic avant, the Medical Every traumatic avant, the Medical Every traumatic avant,	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 Y R S 16a. Dec (Gin life) (Gin life) SECI	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) RETARY	LEGAL SECRETARY
2 should be file and Mental Hy Is marked oth aumatic avant	To Be (17. Father's Name (First, Middle, Last) FRANCIS J. MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ALBERT	ne (First, Middle, Maiden Sumame) A NICHOLS ral Route Number, City or Town, State, Zip Code)
permit. Pages 1 and 2 s Department of Health an Important: If itam 27 Is any injury or other trau		JOAN McDONALD(SISTER) 33-	47 14th STREET consistion (Name of ematory or other place)	APT. 2A LONG ISL. CITY, N Date 20c. Location - City or Town, State 11100 2/2007 WOODLAWN, MD.
permit. F Departm Importar any injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility HENRY W. JENKIN 16924 YORK RD M	S & SONS CO. ONKTON, MD. 21111.
Physician /Medical Examiner project pr	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Plehne	or respiratory arrest, Approximate Interval Between Onset and Death
wrequires that the death certificat been signed by the attending phy should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ 6 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the Degan Tond Diffe	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No	
Physician: this certifice al director, p	Certification: To Be Co	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attanding F within 24 hours after death. To tha Funaral Director: After completely filled in by the funer.	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.		
	W	30. Name and address of person who completed cause of death (Item 23a) (Typ	D 3141	
Sta Registr	,	SHOAIB HASHMI M.D. 821 N. EUT 31. Date filed (Month, Day, Year) MAY 2 1 2007 33 Registrar's Signature	AW ST. BALTO.,M	D. 21201.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year :42PM MAY MARTIN KICHARD 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death saltimore THE JOHNS HORMAL Social Security Number 6. Sex 7. Age (In yrs. last birthday Under 1 Year If Under 24 Hrs. onths Days Hours Min. 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F Months 578-02-6897 42 Apr 19, 1965 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1√TYes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1517 North Avenue USA 14. Race - American Indian, 12. Was Decedent Ever in U.Sunk Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 600 Wolfe Street Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state S. Wade Director Funeral Service Ronal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUCTISYSTEM ORGAN FAILURE 2 415 Due to (or as a consequence of): 2 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (cries a nonsequence or) 2 Wies CELLULITIS

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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Show

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepertment of health and Mental Hygiene. International times 23a or 28a-f show Important: if the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medicel Examiner must be notified at

sician and burial-tran attending physician use as the been signed by the atte should be detached for

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p ဥ Certification:

resulting in death) Last	Due to (or as a consequence of):	
	LO LYMPHEDIMA	2 4+A15
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
Morbid obesity		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MacUnknown
		4a. Was an autopsy autopsy findings available prior to completion of cause of death? ☑ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Death (Che	ck only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	escribe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At nome, farm, street, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, ity or Town, State)
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knowledge, death occurred at the time, date and place, and duminer: On the basis of examination and/or investigation, in my opinion, death occurred at the	ue to the cause(s) and manner as stated. The time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

12, 2007

State Registrar

Medical

29b. Signature and title of certifie

MATTHEW J. CHUY, DO 7716 31. Date filed (Month, Day, Year) MAY 2 1 2007

00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUHNS HOPKINS HOSPITAL 600 NORTH WOLFF STRHT. BALTIMORIMO 21287

amend 1, 27 per DR. g869 7/12/07 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Alaina NyJay Hughes Month Physician 174 HONEYAL 2007 04 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mcdical Bu Himore Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Yeer) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2/5 F Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County orient: If Item 27 is marked other than "natural", or Items 23a or 28e-f show injury or other treumatic avent, the Medical Examinating the modified at 10a, State Baltimore 1 Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23s any injury or other treumating. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hughes, Ir. Johnnie Lee tinora Murshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Avenue 1549 Myrtle Marshall Elnura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) New athedra 22. Name and Address of Facility HOR FUNERAL 21. Signature of Juneral Service Licensee Bradley-UM SDRING Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PPRUM **Physician** /Medical Due to (or as a consequence of) Examiner Churioamnioni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year should be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only or Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 28b. Time of 28d. Describe how injury occurred completely filled in by the funeral 28c. Injury at Work? 27 Manner of Death 1 XNatural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

MAY 2 1 2007

dd cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar	State of Mai	ryland /		rtment of H tificate of I				007	100	200
			Registrar 1. Decedent's Name (First, Middle, Last,)		Oei	incate or i	<u> </u>	2. Date of Dea		UU/	3. Time of	Death
ı	Physicia /Medic		Robert E. Motley,	Jr.	-				May 15			19:00	М
	Examin	-	4a. Facility Name (If not institution, give					r Location of Death			ounty of Death		
-,-			Montgomery Genera 5. Social Security Number 6. Se		(In yrs. last b	irthday)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		ntgomer	place (State o	r Foreian
	Funeral Director		215-58-9612	M 2□F	55	Yrs.	Months Days	Hours Min.	(Month, Da Sept. 2	v. Year)	Cot	intrv)	
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Lo	cation					10d. Inside Ci	
	a-f sh ifled	ctor	Maryland Montgome	ry	Roc	kvil	L1e					1 Yes	2 No
	ith the	Director	10e. Street and Number	-			10f. Zip Code				n of What Co		
	s 23a	rai	P.O. Box 532	12. Was Decedent Ev	vor in U.S.	13 1	208		pecify Ves or No		ed Stat		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		- 1	Yes, specify Cuba	llspanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify: Wh		
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nd	al Hyg	BeC	17. Father's Name (First, Middle, Last)	_				18. Mother's Nam		Maiden St	urname)		
yla	should be f and Mental I s marked of umatic eve	2	Robert E. Motley,		10	ob Maitir	og Addrage (Straat	Mary Wa and Number or Ru		er City or 7	Town State 7	in Code)	
Σ	nd 2 stalth and 27 is n		Michael J. Motley/	•	53	312 1	Waterwhee	el Ct., R	ockvill	e, MD	20855		
Baltimore,	ages 1 a sent of Heat to Heat		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place Mont 8	+030	sition (Name of natory or other place y um, Inc.	: 200	Date 18,	Bethe		arylan	
3altir	permit. F Departme Importan any Injur once.		21. Signature of Funeral Service Licens			Be	Name and Addre	ess of Facility Ob hevy Chas Maryland	ert A.	Pumph 7557	rey Fu	neral i nsin A	lome/ venue
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	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. COROM	ARY /	PRTU		CAIL				Approximatinterval Bet Onset and	-
	/Medical Examiner			Due to (or as a			ELLI TII S					·	
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P.0	uires that the de signed by the a		Part II. Other significant conditions of	ontributing to death bu	t not resulting	j in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of	death?
rds	requires that the een signed by th nould be detache	ed by	BROWCHIAL AS	THAA, UP	LINARU	TR	ACT INF	ECTION	10	Yes 2	No 3□Pi	robably 4 🗆	Unknown
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Divisi	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	ry - At home, c. (Specify)	farm, st	reet, factory, office		28f. Location City or To	(Street and own, State)	Number or R	ural Route Nur	mber,
	e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination	dge, deat and/or in	th occurred at the to	time, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) a , date and	and manner a place, and du	s stated. e to the cause	(s)
	To the To the To the Complex c	Me	29b. Signature and title of certifier					se number		29d. Date	signed (Mon		
	1		William Min	1- Monul	inc		000	58542		MAY	16,20	707	
1	2		30. Name and address of person who	completed cause of de	eath (Item 23	a) (Type,	Print) ENSING!	rom. Mis	2089	5			
ĺ	St	ate	31. Date filed (Month, Day, Year)		ar's Signature								

			State Registrar		epartment of He Certificate of D	ealth and Mental Hy Death	giene 0 7	16364				
de la la la la la la la la la la la la la	Physici /Medi Examir	cal -	Decedent's Name (First, Middle, Last) Audrey Martha Neihof 4a. Facility Name (If not institution, give street an	d number)	4b. City, Town, or L	2. Date of Domination of Death	Day 13, 2007 4c. County of Death					
	Funeral Director		Laurel Regional F 5. Social Security Number 6. Sex 469-22-7957	105PITal 7. Age (In yrs. last birth 80 Y	Ldul day) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Bi Hours Min. 8. Date of Bi (Month, D Jan 9,	rince (9. Birthy ay, Year) 1927 Minne	place (State or Foreign atry)				
	e Maryland Ba-f show htified at	ctor	Usual Residence of Decedent	10c. City, Town	or Location			10d. Inside City Limits 1 ☐ Yes 2√ No				
	ath with the 23a or 29	Funeral Director	3116 Gracefield Road #		10f. Zip Code 20904		10g. Citizen of What Cour					
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☒ Married 1 ☐ \\ If Ye.	Decedent Ever in U.S. and Forces? /es 2 N No s, Give or Dates:		panic Origin? (Specify Yes or N., Mexican, Puerto Rican, etc.) Specify:						
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Maryland 2	uld be filed Mental Hygia Irked other Itic event, tl	To Be Co	17. Father's Name (First, Middle, Last) Andrew Hagstrom			18. Mother's Name (First, Middle Borghild Aune	st, Middle, Maiden Surname)					
	l and 2 sho lealth and I im 27 is ma ther trauma		19a. Informant's Name/Relationship (Type. Print Rex Neihof/spouse	31	16 Gracefie	nd Number or Rural Route Numb 1d Road #306 Si	lver Spring,	MD 20904				
Baltimore,	iit. Pages artment of hortant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 1 4 X Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee	rom State cemetery	Disposition (Name of crematory or other place)		20c. Location - City or To					
Ba	permi Depa Impo any Ir		21. Signature of Eunerali Service Licensee Royal I S Wade		Baltimore,			Street				
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8760,	ate be executed hysician and he burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of e to (or as a consequence of								
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or Vi	Physici this cer ral direct	To Be		1 ☐ Inpatient 2 ER/Outp	patient 3 DOA Other	4 Nursing Home 5 Res	idence 6 □Other (Specia	(y)				
/ision	Attending Physician: r death. ector: After this certifics by the funeral director, I	Certification:	1 Natural 5 □ Pending investigation 3 □ Suicide 6 □ Could not be determined 28e. F	Month, Day Year) Inj	ury Work? M 1 ☐ Ye							
ă	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the formula of the formu			outlding, etc. (Specify)	death accurred at the time	City or To	wn, State)	A-A- d				
	the Hos nin 24 hc the Fun npletely	Medical	(Check only one) 2 Medical Examiner: On and	the basis of examination and manner stated.	or investigation, in my opi	inion, death occurred at the time	, date and place, and due t	o the cause(s)				
	wit To	2	29b. Signature and title of declinia			24035	29d. Date signed (Month, May 14,	2007				
	Sta	ate.	30. Name and address of person who completed E.S. Machado, M.D. 31. Date filed (Month, Day, Year)	cause of death (Ite <i>m</i> 23a) (T 3110 Gr 32: Registrar's Signature	racefield R	oad Silver.	Spring, M.	D 20904				

DHMH 17 Rev 1/2001

State

Registrar

MAY 2 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 Peyton Edward Nowlin May 16, 3:50 P.^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Ctr, Subacute Randallstown Baltimore 8. Date of Birth (Month, Day, Year) 9. Birth Country) Oct. 31, 1919 Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1XXM 2□F Months Days Hours 220-03-9615 87 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No Maryland Baltimore Reisterstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 509 Glen Granite Road 21136 of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2XXXNo If Yes, Give Year or Dates: 1XX Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Locksmith Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peyton Nowlin Pearl Laura Crusey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas S. Spadaro (Brother in law) 322 Leyton Road; Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 19, XIX Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Othe (Specify) Druid Ridge Cemetery 2007 Pikesville, Maryland of Fur ereco vice Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, Hemain 11605 Reisterstown Road; Owings Mills, Maryland 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Impordiate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown s contributing to death but not resulting in the underlying cause given in Part 1 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★XUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

Physician /Medical **Examiner** Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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T is marked other than "natural", or Items 23a or 28a-f shor traumailc event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If flem 27 is marked other than "natural"; or harmone. In Jury or other traumatic event "than "natural"; or harmone.

the Maryland

burial-tra þ After

Physician/Medical

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Completed

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Certification: To

Medical

29a. Certifier

(Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after dea.... the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760.

Part II. Other significant condition
25. Was case referred to medical examiner? 1 ☐ Yes XXNo
27. Manner of Death XXNatural 5 □ Pending

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

XX CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RANDALLSTOWN

29b. Signature and title of certifier

MD

29c. License number D54352

MIRCE A TODOR

29d. Date signed (Month, Day, Year) MA 2007

MD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) NORTHWEST HOSPITAL SHOL OLD COURT ROAD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

10

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** Month Thomas J. Najar May 3:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) November 3, 1911 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York Funeral Days Hours 1 M 2 □ F Months 081-10-1526 95 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Potomac 28a-f 10e. Street and Number 10g. Citizen of What Country? ō 7784 Heatherton Lane Items 23a 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No WWI If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. White Completed by 3 Nidowed 4 Divorced Specify: Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Plastics Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 Is marked oth Be James Najarian Lucy Bobian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Najar / Daughter permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 7784 Heatherton Lane, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 20, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licenses Gazdetal M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 2 Years /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 2 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner igned by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Renal Insufficiency 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1□ Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient Certification: To 2 X ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After 1 🕅 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month, Day, Year) D060129 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) Brent Kenneth-Grotch Cole, MD 5530 Wisconsin Avenue, St. 730, Chevy Chase, Md 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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21. Signature of Funeral Serves, Legister M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Maryland 20850 23. Part I. Enter the disease, or compilations transported the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Physician (Medical Examiner Physician (Medical Examiner Physician (Medical Examiner) Sequentially list conditions, any issue of a part in the past 12 months? The properties of the properties of the properties of the past 12 months? The pas	Z	alth ar 27 Is 127 Is												
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		ne Hoo	Medical	(Check only 2 Medical Exam	niner: On the basis of ex	amination and/or in	vestigation, in my o	pinion, dea	th occurre	ed at the time,	date and pl	ace, and due t	o the cause(s))
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130. Name and address of person who completed cause of death (Item 23a) (Type, Print) POSCIILA COLICADA HORMO 911 Russell Avenue Gaittersburg, mo 20879	(l			completed cause of deat	h (Item 23a) (Type,	sell Ave	nue	Ga	ittersb	wa	mo a	0879	,
State Registrar Puxella Cellular 40 mo 041744 may 10, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Print Cellular 40 mo 911 Pussell Avenue Gentlers burg, mo 20879 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 1 2007 1000 1000 1000 1000 1000 1000 1000 1000 100				31. Date filed (Month, Day, Year)	32. Registrar's	Signature	backs							

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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other trawmatic event, the Medical Examiner must be notified at once.	Į	LUDMILA OBORIN /	FRIEND			TABLEMER		BALTIMORE		1209
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Physician		23a. Part I. Enter the disease, or co failure. List only one cause on	mplications that caused	the death. I	Do not enter	the mode of dying	g, such as cardia	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
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Box 68760, e death certificate be e the attending physicia ed for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	me of pregna					23d. Date of de	
certif	lä.	past 12 months?	1 Live birth 4 Pregnant at	time of deat	- H	Fetal death 3 Other (Specify)	Ectopic pre	gnancy	Month	Day Year
Box ic death the atte	ysi	1 Yes 2 No 9 Unkno			5(Jiller (Specify)				1
b.O. Box that the deatl		Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the	underlying cause	e given in Part I.	23e. Did to	obacco use contribut	te to the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	d by							1 Yes	s 2 🗸 No 3	Probably 4 Unknown
rds requi	Completed							24a. Was		re autopsy findings available r to completion of cause of
e law e has ge 2 sj	립						_		rmed? dea	th?
tal Rec cian: The l certificate l		25. Was case referred to medical				26 Pla	ce of Death (Che	1 Yes	2 No 1	Yes 2 No
Division of Vital Records, P.O tal or Attending Physician: The law requires that it after death. **All Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detaxed.	Be	examiner?	Hospital: 1 Inpatie	ent 2 E	R/Outpatie		Othor:	sing Home 5	Residence 6 🗸	Other: Scene
of Ving Physical After this	2	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	Jry 3	28b. Time o		jury at Work?		how injury occurred	
Division of Npital or Attending Phours after death.	Certification:	1 V Natural 5 Pendin	(Month, Day, Y	(ear)		1	Yes 2 No			
ivision I or Attend after death. Director:	ig	2 Accident Investig	280 Place of In	njury - At hon	ne, farm, sti	eet, factory, office	building, etc.	28f. Location (Street and Number (or Rural Route Number, City
Div tal or rs aft red in	팋	3 Suicide 6 Could r determine						or Town, S	State)	
		20a Cortifica	sician: To the best of m	y knowledae	e, death occ	curred at the time.	date and place, a	and due to the caus	se(s) and manner as	stated.
To the Hoss within 24 ho To the Fun completely	Medical	Check Only	ner:On the basis of exa							
P. Wiring	ğ Z	29b. Signature and title of certifier	and manner stated.	_		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
		XIIIXV	< //			0.0	C.M.E.		May 17, 2007	,
17	1	30. Name and address of person w	ho completed cause of	death (Item 2	23a)					
6		. \	ssistant Medical E	•	111 Pe	enn Street, Ba	altimore, MD	21201		
St	ate	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	· All	we				·
Regis	rar	MAYZI	2007	The will be	0.7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-03750 State of Maryland / Department of Health and Mental Hygiene Robert Eugene Perlie, Jr. Certificate of Death 1- For State Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) May 17, 2007 Physician/ 0236 hrs ROBERT EUGENE PERLIE JR. া Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A Baltimore City Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex oreian **Funeral** Months Days Hours Country) MD. APR.9,1991 16 216 72 3469 Director 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Yes 2 No s 23a or 28a-f show a e notified at once. BALTIMORE N/A MD. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Eygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21202 1202 E. EAGER ST. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2X No Yes Specify BLACK Yes 2X No specify: Yes, Give Year Divorced 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ⋧ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A STUDENT 9TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DENISE ADDISON ROBERT E. PERLIE, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1202 E. EAGER ST. BALTO, MD. 21202 (mother) DENISE ADDISON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State MAY23,2007 BALTO, MD. MEM.PK. KING Donation 5 Other Specify: 22 Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME Signature of Funeral Service License 23a. Part I. Enter the disease, or complications that caused the learn. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and **Physician** Death Andrea. a. Gunshot wound of head Immediate Cause (Final disease **kaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED UNPENDED attending physician or use as the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Day Year 23b. Was decedent pregnant in the Fetal death I ive birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the atte Unknown 23e. Did tobacco use contribute to the cause of death? Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, certificate has been sector, page 2 should prior to completion of cause of autopsy death? performed? 2 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be Other₄ Hospital: 1 Residence 6 Other: examiner? Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA this 1 🗸 Yes ۵ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) May 17, 2007 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Subject was shot Certification: 0219 hrs Yes 2 V No Natural Pending hours after death Director: d in by the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 200 North Dalias Court, Baltimore, MD Could not be 3 Suicide determined (Specify) Local Street the Funeral 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in rny opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 17, 2007 O.C.M.E.

State 31. Date filed (Month, Day, Year)

Registrar

MAY 2 1 2007

Ling Li, MD

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month James Edward Parrish III /Medical 4a. Facility Mame (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, May 9, 5. Social Security **Funeral** 1 X M 2€ F Months Director none Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2√2 No **Funeral Director** Baltimore **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 6913 McLean Blvd 21234 USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or itel any injury or other traumatic event, the Medical Examine once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none none none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Edward Parrish Annette Pendergrass ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Bayview 4940 Eastern Avenue Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 🖾 Other (Specify) in State 21. Signatur of Funeral Struce Licensee Ron 21d S. Wade State Anatomy Board 655 W. Baltimore Street 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) a. Physician /Medical (or as a consequence **Examiner** Sequentially list conditions, if any Lading Limit of Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse up Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) by the a Division or Vital Records, P.O. 9 ☐ Unknowf þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes No has e 2 page autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural (Month, Day Injury M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (N

ontH. Dav. Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #26, perMD, C867, 5/21/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician PRUCE EARL 12:05A MAY 16 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SINAI HOSPITAL BALTIMORE If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours 1**X** M 2□ F 97 Director 01/30/1910 MD212-01-7151 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show notified at show 1 X Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code "natural", or items 23a or edical Examiner must be r S AVENUE, APT.

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 6503 PARK HEIGHTS USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical College (1-4or 5+) Elementary/Secondary (0-12) is marked other than IBRARIAN NEWS POST NEWSPAPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ဥ SAMUEL PRUCE FANNIE PUMPIAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Department of Health as Important: If Item 27 is any injury or other trau once. 6503 PARK HEIGHTS AVENUE, APT. 4-H, BALTIMORE, MD BETTY L. PRUCE / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS 05/18/2007 | BALTIMORE, MD neral Service Licen SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ardiac Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 KAER/Outpatient 3 □ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 5 ☐Pending investigation Hospital or Attending 1 Natural s after death.

I Director: Al 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

State Registrar 29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

omon Mi Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	ryland / l	Depa <i>Cer</i>	irtment of H tificate of I	ealth and N D <i>eath</i>		giene Reg. No.	2007	15372
ı	Physicia		1. Decedent's Name (First, Middle, William	Last) K i ng		Pc	ound		2. Date of De May 8,		Year	3. Time of Death 3:30 pm
	/Medic Examin		4a. Facility Name (If not institution, 2024 Drummond R				Baltimo			Ba	ounty of Death	
ı	Funeral Director		219-16-6798	6. Sex 7. Age 1 ★ 2 □ F	(In yrs. last bii	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept.	28, 19	9. Birth Cou 924 Mar	place (State or Foreign intry) y land
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltim		10c. City, Tow							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28a at be not	Direc	10e. Street and Number 2024 Drummond				10f. Zip Code 21228			10g. Citize	en of What Cou	intry?
036	be filed within 72 hours after deeth with the Maryland nat Hygiene. do other than "natural", or iteme 23a or 28a-f ehow event, the Modical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☼ Marrie 3 □ Widowed 4 □ Divorced			I	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 1 No	ispanic Origin? (Sp. n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Wh	, etc.
9500-91212	within 72 ho ene. then "naturi te Medical I	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 1 2	s Education t grade completed) College (1-4or 5+)	(Give life. L	tent's Usual Occupi kind of work done of DO NOT use retired Employed	during most of world	king		of Business/li	
Maryland 2	o d ii b ≥	To Be Co	17. Father's Name (First, Middle, L John C.	.ast)				18. Mother's Nam Bertl				
	and and is m		19a. Informant's Name/Relationsh Deborah Pound D		100		g Address (Street					
Baitimore,	@ C		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (So	3 □Removal from State	Baltin	of Dispo	sition (Name of Crefitation	May	Date 10, 200	20c. Loc Bal	ation - City or 1 timore,	own, State Maryland
Balt	permit. Page Department: Important: if eny injury or once.		21. Signature of Funeral Service L	100 415 00		22	Name and Address					
i,	Physician		23a, Per Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused to only one cause on each line mult	ple S					irrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	e.	resulting in death) Sequentially list conditions,	b. Due to (or as a	ary 1		ten A	clere	र्धाः			
ر ص	cate be executed physicien and the burial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a						· -		
(68760		Medical	IF FEMALE:	d								
O. Box	The law requires that the death certifi ete has been signed by the attending page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□ Unknown	Fetal death		Ectopic pregnancy Other (specify)			23	3d. Date of deline Month	very Day Year
Records, P.	equires that en signed t ould be det	þ	Por A Son	ns contributing to death bu	t not resulting	in the u	nderlying sause giv	en in Part I.		tobacco us	e contribute to	the cause of death?
	hysician: The lawr his certificete has be il director, page 2 sh	Completed	with aspir	ration	Slea	P	April	19	1 ☐ Yes	ormed? 2 No	24b. Were aud prior to death? 1 \(\sum \text{Yes}\)	topsy findings available completion of cause of
of Vital	hysiciar his certif I directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatien	it 2□ER/O	utpatier		4 Nursing H	ome 5 Des	idence 6	□Other (Spec	ufy)
Division o	ng P fter t nera	Certification:	27. Mann of Death 1 atural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	Year) 28b.	Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe			
Ž	ital or Atture after dura Directure Directured Directured in by		4 Homicide determi	building, etc.	(Specify)				City or To	wn, State)		ral Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only 2 Medical E	g Physician: To the best of Examiner: On the basis of and hanner stat	examination a	nd/or in	vestigation, in my o	pinion, death occu	, and due to the rred at the time,	, date and	and manner as place, and due signed (Month	to the cause(s)
	7 /		(lan)	Clause of de	w	Cluna	D. Print)	3063 00 Gei	1		5/91	swille M)
	0 1		30. Name and address of person 31. Date filed (Month, Day, Year)	32. Registra	-711	M	D, 7	00 Gei	pe Rd	,	21	228
	Sta Registi		MAY 1 8 200		K A	rechi	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner more Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 ★M 2 ☐ F 2-40-342 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be 39 inston 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give American Indian 11. Marital Status Black White etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced ear or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical than and ry (0-12) College (1-4or 5+) marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. Name (First, Middle, Last) 17. Father Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ■Burial 2 □ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 21212 ld. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed as the burial-tran and Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: use yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth Month Day Į in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) should be detached 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autons perform 2 certificate 1∐ Yes Division or Vital filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 4 🗆 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) ည After this 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation (Month, Day Year) Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 □Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ō Hospital 24 hours 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 227 St Paul Place Baltimore Lenter Medical

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2

20U i

32 Registrar's Signature

Physician /Medical Examiner certificate be executed

Department of Health an Important: If Item 27 Is any Injury or other trau

Pages '

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

or i

hours after

within 72 h

12 should be filed who hand Mental Hygien Is marked other the

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

and burial-tran attending physician the as use for t page 2 certificate After this

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

death.

Director: filled in by the

To the Hospital or At within 24 hours after d
To the Funeral Direct completely filled in by

Examine Physician/Medical Completed Be 2 Certification:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Illnknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 ☑ Natural

5 Pending investigation 6 □ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 ☐ Homicide

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cerlifier (Q

29c. License number .30469 29d. Date signed (Month, Day, Year) 2007. 17

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
NBVELLANKS 8850 Columbia 100 BARKWAY: + 308 COLLYBIA, MD. 21045

State Registrar

Medical

31. Date filed (Month, Day, Year)

2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 Per Phy G86/5/24/07 JH

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 18210PM James Sheppard John Sheppard MAY 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Nov 5, If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**∑**M 2□F Maryland 212-28-6080 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 nouss array and Mental Hygiene.
I Is marked other than "natural", or Items 23a or 28a-f show I is marked other than "natural", or lems 23a or 28a-f show a went, the Medical Examiner must be notified at 1 Y Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 McMechen Street USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black 3 ▼ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk printing unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Pages 1 and 2 should traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Sharon Ayers/daughter 3613 W. Lexington Street Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5MOther (Specify) in state 21. Signature of Funeral Drivice Licensee on 3 d S. W de, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD $21201\,$ irector 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death ASPIRATION Physician 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of ENCEPHALOPATHY Examiner 1 WEEK ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant S'HEPAARD, JAMES 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ABRILLATION 1 Yes 2 No 3 Probably 4 Monknown Completed HYPERTENSION. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perforn the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-18613-Maun . A.M. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUHAMMAD SAM, M.D. 900 S. CATON AVE- BALTIMORE, MD. 21229.

Registrar

DHMH 17 Rev 1/2001

State

MAY 2 1 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Mary 2:40 AM 0 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Health Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🂢 F Yrs. 87 Nov 27, Director 217-14-8264 1919 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f show Hygiene. other than "natural", or items 23a or 28a-f shov ent. The Modical Examinar must be contilled at 1 ☐ Yes 2√ No Director Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21228 719 Maiden Choice Lane CR13 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cotlege (1-4or 5+) Elementary/Secondary (0-12) 12 office manager financial Pages 1 and 2 should be filed v iment of Health and Mental Hygie tant: if Itam 27 ie marked other t ijury or other traumatic event, ib other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Spencer Mary Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rob Dixon/executor 1148 Court of Fiddlers Green Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from 81ate Department in important: if eny injury or once. 4 Donation & Other (S 21. Ignalili Funeral Servi State Anatomy Board 655 W. Baltimore Street in Baltimore, MD 21201 23a, Part1. Enter the disease, or complications that caused the stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Pnysician a Metastatic Breast Cancer /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred After 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/10/07 ロイヤ377 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Lane, Catonsville, mb 21228

Registrar DHMH 17 Rev 1/2001

State

mn

32. Registrar's Signature

Deneen Bowlin 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12, 2007 8:30 AM M Blanche H. Smith May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Magnolia Center Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 94 579-01-7321 Director Nov 18, 1912 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2√ No Director MD Prince George's College Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 should be filed within 72 hours after death with and Mental Hygiene.

Is marked other than "natural", or Items 23a or? 3407 Marlborough Court 20740 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: q Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 seamstress clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Bennet Haley ည Mary Etta Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Magnolia Center 8200 Good Luck Road Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 MDonation 5 ☐ Other (Specify 21. Signature of Luneral Service Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 26a. Part1. Ener the disease, or complication shock, or heart fallure. List only one cal Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Colon with **Physician** arcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at the detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 27 No 1 □ Yes 3 Probably 4 Unknown scherotic Chrdievasevlar 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mapher of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital c within 24 hours af within 24 hours a

To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Rensburg Rd Hyhltru: He MA 2078 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Ma	ryland		artmen <i>rtificat</i>					giené Reg. No.	-001	16	378
7			1. Decedent's Name (First, Middle, Las	st)							2. Date of De Month	ath Day	/ Year	3. Time	of Death
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	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City,	Town, or	Location			4c.	County of Dea		
		2	Franklin Woods	Center								В	altimo		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. la	ast birthday)	ff Under Months	1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir 7 – 21 –	th y, Year)		nhplace (Stat ountry)	-
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	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
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Baltimore,	permit. Page Depertment important: if eny injury o		21. Signature of Funeral Service Licer	1500			Name ar	oh N	Za	anni	no Jr.	Fu	neral	Home ²	21224
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8760,	The law requires that the death certificate be executed to the has been signed by the attending physician and the has been signed by the attending physician and the burial-transit or use as the burial-transit or the second or	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (of as a			rit	·is							
O. Box 6	that the death certifics ed by the attending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 🗌 Fetal	death 3[Ectopic p						23d. Date of d Month	elivery Day	Year
Δ,	res that the igned by be detact		Part II. Other significant conditions of	contributing to death bu	t not resu	ıfting in the u	nderlying o	cause give	en in Part	1.	23e. Did	tobacco	use contribute	to the cause	of death?
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5	Physician: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatier	nt 2 🗆 I	ER/Outpatie	nt 3 D	OA Oth			me 5 Res		6 □Other (Sr	necify)	
of			27. Manner of Death	28a. Date of Injur	v	28b. Time o		28c. Injun Worl			28d. Describe				
on	nding f th. :: After e funer	at lo	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	rear)	Injury	M		Yes 2]No					
Division	i or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined		ry - At ho : (Specify	me, farm, st	reet, factor	y, office			28f. Location (City or To	(Street ar wn, State	nd Number or . 9)	Rural Route N	lumber,
۵	ospital hours unerei ly filled	cai Ce	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exa	nysician: To the best o miner: On the basis of	of my know	wiedge, deat	h occurred	at the tin	ne, date a	and place,	and due to the	cause(s) and manner	as stated.	Se(s)
	To the H within 24 To the Fi	Aedicai	оле)	and manner stat											
	T Son	Σ	29b. Signature and title of certifier				29c. License number 29c					zyd. Da	29d. Date signed (Month, Day, Year)		
	0		111	7 ~ 1	>	*		D.	, 340	62	-	<	5 181	77	
1	5		30. Name and address of person who	completed cause of de	ath (Item	23а) (Туре,	Print)				2000		0	(>	4061
		Į	31. Date filed (Month, Day, Year)	> M D	78	45	19	+Kn.	000	4 (<	500	64	SN SS	rnie	IND
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DHMH 17 Rev 1/2001 **OCME 2006**

Registra

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #1, 29d, perMD, 6867, 5/19/07 The Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OJ Day (29 1200 Shilpan Talati 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 X M 2 □ F Yrs. 40 Feb. 2, 1967 India 219-06-0494 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Tyes 2 No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 United States 11458 Stewart Lane, Apt. B-1 Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Asian-Indian Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery store Cashier 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) V. Kusumben I. Indravadan Talati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11458 Stewart Lane, Apt B-1 Silver Spring, MD 20904 Daxaben S. Talati/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐Removal from State 5/10/2007 W. Arundel Crematory Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. marita R 1411 Annapolis Road Odenton, Maryland 21113 24homas 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MASSIVE 6 ASTROPMESTINAL Due to (or as a consequence of): RTAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LIVER (At cornie IRROSIS Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OHEMO DATHU ACLITE 3 ☐ Probably

Physician /Medical **Examiner**

physician

Physician

/Medical

Examiner

Funeral

Director

28a-f show

or items 23a

'natural",

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical

ns 23a or 28a-f sh must be notified

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

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Division or Vital Records, P.O. Box 68760,

Physician: The

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Examiner Physician/Medical Be Completed by Certification: To filled in by

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PAILURG,	RESPIRATORY	FAILURE	24a. Was an autopsy performed? 1 ☐ Yes 2☒ No 24b. Were autopsy findings availat prior to completion of cause o death? 1 ☐ Yes 2☒ No 1 ☐ Yes 2☒ No			
25. Was case referred to medical		26. Place of Dea	ith (Check only one)			
examiner? 1 ☐ Yes 2 [x] No	Hospital: 1X Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)			

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated one 29d. Date signed (Month, Day, Year) 05/09/2007 29c. License number tle of certifier 29b. Signa

and address of person who completed cause of death (Item 23a) (Type, Prin Name MRWINSUI 100

7600 Carroll Avenue Takoma Park, MD

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 1 9



			1 _ For	State of M	aryland		artment			ınd M	ental Hy	100	007	16381
			Registrar 1. Decedent's Name (First, Middle, Las	+)		061	incare	OIL			2. Date of D	Reg. No.		3. Time of Death
	Physici /Medic		DOROTHY	Α	WILL	IAMSO	7				Month MAY	Day 5 ,	Year 2007	7:05 ^a м
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	f Death			ounty of Death	
			ST. THOMAS MOORE			- 4 1- 1-45	If Under		TSVI:		9 Date of Bi		RINCE GI	EORGE Solace (State or Foreign
п	Funeral		5. Social Security Number 6. Se	M 2. STF 7. Ag	je (In yrs. la	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D		Cou	ntry)
	Director		131-32-3191 Usual Residence of Decedent		64					<u>}</u>	July 3	0, 194	12 5	.C.
	/land		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Mar Mar	tor	Md. Prince G	eorge's			Ca	apito	ol He	ight	s_			1 X Yes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ta Madical Exercities I was be notified at	al	533 Opus Avenue						743				ited St	
	tams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	•	3. 13.	Was Deced If Yes, spec	ent of His	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or N Rican, etc.)	0- 14	 Race - Ameri Black, White, 	
36	or h	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	1 ☐ Yes 2 🔀 If Yes, Give	No		1 ☐ Yes 2	2⊠ No	Specify:			s	pecify: R1	ack
8	tural tural		15. Decedent's Ed	Year or Dates:		16a Dece	dent's Usua	I Occupa	tion			16b. Kind	d of Business/In	
5	in 72	olet	(Specify only highest gra-	de completed)	F.)	(Give	kind of wor DO NOT us	k done d e retired)	uring most	t of worki	ng			
21215-0036	i with	Completed	Elementary/Secondary (0-12) 12th	College (1-4or	5+)	F	inance	e Off	ficer				Privat	e
פַ	e filed It Hygi other vant, I	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden S	umame)	
<u>a</u>	should be nd Mental marked c	၉	James Austin							A	nn Aus	tin		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygene. Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show than treumatic event. The Madical Exercities II and be notified at	-	19a. Informant's Name/Relationship (7	ype, Print)			•	•				er, City or	Town, State, Zij	o Code)
	and and m 27		Leon Leake / Nep	hew	ook St		hode :				2 Was	h., DO	2000: ation - City or T	
altimore,	Pages 1 nent of H int: If Ital		20a. Method of Disposition 1208urial 2 Cremation 3	Removal from State		ace of Dispo metery, cre								
Ë			`4 □Donation 5 □ Other (Specify		Ce	dar H			-4 1	5-12			itland,	Md.
Bal	permit. Departr Importa any inj		21. Signati re of Funeral Service Licen	See A	Ma P	10 .1	2. Name an			Ca	pitol		_	
	TO TO C		23a Part Enter the disease or amo	plications that cause	d the death	Danot en	425 Ma	aryla e of dvino	and A	ve.,	NE or respiratory	Wash. arrest	, DC	20002 Approximate
			23a. Pan1. Enter the disease, or pmp shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine.			۸۸			7115	00-	T11	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as	1 =	ones of):	XCC1	KI	101		LIVET	IKC	TICH	-
	Examiner			Col	ON V	ADD V	٠ .	AP.	TER	Y	DIS.	EAC	F	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):		11/2		/		. 70		
1760,22	be executed sician and burlal-transit	Examin	that initiated events	C										
0,0	an an rial-tr	EX	resulting in death) Last	Due to (or as	a consequ	ence of):								
376	a × a	Ical		d										
68	The law requires that the death certifical tehas been signed by the attending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE:	00 1/										
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal	death 3	⊒Ectopic pr					23	3d. Date of deliv Month	ery Day Year
	the a	yslc	1 ☐ Yes 2 ☐ No 9 🛣 Unknown	4⊡Pregnant a 9⊡ Unknown	it time of de	iain 51	Other (sp	ecity)						
P.O.	that the		Part II. Other significant conditions c	ontributing to death t	but not resu	ılting in the u	inderlying c	ause give	n in Part I		23e. Did	tobacco us	e contribute to	the cause of death?
ds,	uires sign	d by	End Col	a 20	Do	11 0	08	Ses	o a	re	1	Yes 2□	lNo 3□Pro	bably 4 🛭 Unknown
COL	w require been signature	Completed		0		20	101		vat	1	24a. Wa		24b. Were aut	opsy findings available
Re	The lav	Ę.		ary	V)- (1	1000		ou co		per	opsy formed?	prior to co death? 1 ☐ Yes	ompletion of cause of
ta		a	25. Was case referred to medical						26. Place	of Death	Check only	2 ₩ No one)	1 103	20110
<u> </u>		0	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpati	ient 2 🗆 E	ER/Outpatie	nt 3□ DC	Othe	or: 4 □ Nu	ırsing Ho	me 5 🗆 Re	sidence 6	☐Other (Spec	ify)
Division of Vital Records,		T:U	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ury ay Year)	28b. Time o	of 2	8c. Injury Work	at		28d. Describe	how injury	occurred	
Ö	Attanding or death. actor: After by the fune	atle	2 Accident investigation				М	1 🗆 \	res 2□					
<u>≅</u>	r Atter de iracte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of In	ijury - At ho tc. <i>(Specify</i>	me, farm, st	reet, factory	, office				(Street and own, State)	Number or Rui	al Route Number,
	To the Hospital or Attant within 24 hours after deatl To the Funaral Diractor: completely filled in by the			1		udade : .	4b	-4.45		d also		n. anu == (=)	and manager	ctated
	Hospital 24 hours a Funaral I	edical	29a. Certifier 1XXCertifying Ph (Check only 2 Medical Exam	ysician: To the best niner: On the basis of and manner s	of examinat	wiedge, dea ion and/or ir	tn occurred rvestigation	at the tim , in my op	ie, date an pinion, dea	id place, ith occurr	ed at the time	, date and p	olace, and due	to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner s			290	. License	number			29d. Date	signed (Month	, Day, Year)
	F ₹ F 8		VIII D.	1111	aut	t		DL	15h	190			5-10-07	
			30. Name and address of person who	completed cause of	death (Item	23a) (Type	, Print)		-	-			7-15-7	
	5			LO6 IRVINO				WASH	INGTO	ON. I	C.200	18		
	Sta	ate	31. Date filed (Month, Day, Year)			ture					, , , , , , , , , , , , , , , , , , , ,			
	Regist	rar	MAY 2 1 ZUU/	Jan Barrell	40.00	1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:08a M CANDEE 0. WILLIAMS-HARRIS MAY 5, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGE"S CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov . 3 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Wash., DC 1 □ M 2 🕱 F Months Days Hours 31 Nov. Director 577-02-3479 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1¥1Yes 2 □ No Director D.C. Washington Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1435 Bangor St., S.E. 20020 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Instural, or items 2 important: If Item 27 is marked other than "natural", or items 2 any Injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2K Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Lester Williams Pauline Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Crowder/Step-Sister 4616 Health St. Capitol Heights, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Buria! 2 K Cremation 3 ☐Removal from State 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Md. 4 Donation 5/18/07 21. Signature of Funeral Service L 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., D.C. 20002 omplications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 40 Cardi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760ポッ Due to (or as a consequence of) Tum burial-trar Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 92Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate 1□ Yes 214No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica etely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 LInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1.☐ Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor **To the Fune** сотрletely fi and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P0037066 05-05-200 t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6188 040 n / 1/1 Rd #701 Oxon Hill, MO 20745 7.08aigbeogu, no 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar	State of Maryland	Certificate of L		Reg.	print you you way	16383
Physicia /Medica	n	JESSIE MAE	WATSON			2. Date of Death Month 05–16–20		3. Time of Death 7:40 A. M
Examine		a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death		4c. County of Dea	th
		FAIRFIELD NURSING		CROWNSV	ILLE If Under 24 Hrs.	8. Date of Birth	A.A. CO	thplace (State or Foreign buntry)
Funeral Director		215-24-6691	У Д F 92	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 08-19-19	914 Co	NC
with the Maryland a or 28a-f show be notified at		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Location				10d. Inside City Limits 1 Yes 2 □ No
the M	Director	MD 10e, Street and Number		BALTIMORE 10f. Zip Code		10g	. Citizen of What Co	ountry?
with with the r			TA AVE	21201			USA	
d Z1Z13-UU30 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	호	1100 PENNSYLVAN 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🛣 N♂ If Yes, Give			ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify:	
5-UUS6 72 hours af 'natural', or dical Exam	Completed by	3 ☐ Widowed 4 ☐ Privorced 15. Decedent's Ed (Specify only highest gra	Year or Dates: ucation de completed)	16a. Decedent's Usual Occup	during most of work		b. Kind of Business	/Industry
IZI vithin ne. han "	m d	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired DOMESTIC	"		HOUSEKEE	PER
Maryland 2121 d 2 should be filed within th and Mental Hygiene. 27 is marked other than traumatic event, the Me		17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	iden Surname)	
d be fed be fed of ceve	മ്	GEORGE WATSO			IDA B	. RIDDIO	CK	
Shoul and Ma marl	۵ .	19a. Informant's Name/Relationship (7		19b. Mailing Address (Street	and Number or Rui	ral Route Number, C	City or Town, State,	Zip Code)
and 2 and 2 ealth a n 27 is		ANDREW MASON/GRE	AT NEPHEW	910 SAND BRO				
of Fire r		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	lace of Disposition (Name of emetery, crematory or other place RBUTUS	ce)		ALTIMORE,	
Baltimo permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer	Morlan	1701 LAU	RENS STRE	ET, BALTO)., MD 21:	ONS F.H., IN 217
Physician /Medical		23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a. Due to (or s a consequ	saclas acc	edur	or respiratory arres	st,	Approximate Interval Between Onset and Death
68760, tificate be executed tificate be executed to physician and as the burial-transit	al Examiner	Sequentially list conditions, in any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to for as a consequence. — Due to for as a consequence.					
death cert	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 ☐ Ectopic pregnanc	у		23d. Date of d Month	elivery Day Year
ords, P.O. requires that the een signed by the	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying cause given	ven in Part I.			to the cause of death? Probably 4 Munknown
e lar has	Completed					24a. Was an autopsy perform 1 Yes 2	prior t	
Vital F Iclan: Th certificate ector, pag	BeC	25. Was case referred to medical				th (Check only one)	
or Vita Physician: this certific	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 10A			nce 6 □Other (S)	pecify)
C E aff a		27. Manner of Death 1		28b. Time of 28c. Inju Injury M 1	iry at irk?]Yes 2 □ No	28d. Describe hov		
Division al or Attending s after death. Il Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f.	Medical C	29a. Certifier (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurred at the tation and/or investigation, in my	time, date and place opinion, death occ	urred at the time, da	ite and place, and c	ue to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier		29c. Licen	38958		0d. Date signed (Mo	
3	(30. Name and address of person who	Sull 208	Crain Hickory	us Sw	Olin Bo	ime m	DH061
St Regist	ate rar	31. Date filed (Month, Day, Year)	3. Registrar's Sign	ature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Warns Sr. May 18, A^M 2007 8:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Genesis Eldercare - Heritage Center Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) November 22,1933 9. Birthplace (State or Foreign Country) Maryland **Funeral** 6. Sex 7. Age (In yrs. last birthday Days Hours 1[XM 2□ F 73 214-30-3892 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any filury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Aldworth Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Machinist Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward George Warns Evelyn Lucille Huffines ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 703 Aldworth Road, Dundalk, Maryland Marylouise Warns wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State May 21,2007 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licens 23a. Part1. Inter the disease, or complications that shock or leart failure. List only one cause in Immediate in se (Final disease or condition resulting in death) caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death **Physician** /Medical Examiner Saguer fielly feet conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an has autopsy performed 1□ Yes 2□Mo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: L_o 1 ☐ Yes 2 ☐ Mo 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospita, ... within 24 hours after death.

To the Funeral Director: Af

7

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my calculated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day MAY 200^Ygar **Physician** 20 9:30 am BETTY G. WALTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 19842 GORE MILL RD FREELAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/15/1913 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours I OWA 1 ☐ M 2 🕱 F 94 Yrs. 155-30-8578 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location r then "naturel", or Items 23s or 28e-f show the Madical Examiner nast be notified at 1 ☐ Yes 2 No FREELAND BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21053 USA 19842 GORE MILL RD Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER 4YRS HOUSEWIFE other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be flit partment of Health and Mental Hy portent: If item 27 is marked oth y injury or other treumetic event Be ZELLA B. HARPSTER GILBERT B. GRAVES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19842 GORE MILL RD FREELAND, MD. 21053. JEWEL WALTON(DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or GREEN MOUNT CREMATORY 05/23/07 BALTO CITY, MD. 22. Name and Address of Facility 21. Signature of Fureral Service Licens SONS CO. HENRY W. JENKINS & SONS C 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deat

4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Day Month for 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 donknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 ☐ Yes 26. Place of Death Check only one funeral director Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 | Pending 2 🗌 No 1 🗌 Yes death. investigation 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 T Homicide within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

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State

CARMEL RD PARKTON, MD.

21120.

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14A MT.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

ROBERT HSIAO M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lorin Lee Wheatley, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Day Month Medical Examiner 1930 hrs Lorin Lee Wheatley Jr May 9, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1001 North Division Street Salisbury Wicomico 5. Social Security Number un K6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Months Davs Hours Min. Director Country Maryland 1 X M Yrs Sept 12, 1976 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show notified at once. MD Wicomico 1 Yes 2 X No Salisbury Director 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country 1001 N. Division Street 21801 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes 3 Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify: Specify: white "natural", ò 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry npleted during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n d other than ", the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 0 boats waterman Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tic event, Lorin Lee Wheatley Sr Barbara Zembower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Somers Cove Crisfield, MD 21817 Lorin L. Wheatley Sr/father 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: 21. Si penure of El neral Service Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. een Onset and /Medica Hypertensive atherosclerotic cardiovascular disease Death -xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical tending physician are use as the burial -X UNPENDED #232,PII,27,perME, G868, 6/11/07 TI The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 No 3 Probably 4 ✔ Unknown Cocaine use, diabetes mellitus Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death' ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Other 4 Hospital: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this 1 V Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Director: 24 hours after death. Funeral Director: Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ça To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Registra

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

Laron Locke MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 10, 2007

		For State Registrar	State of Maryland		rtment of He tificate of D	eath	Re	g. No.2. U U /	16387
Physici /Medio	an	1. Decedent's Name (First, Middle, Last) ROSAMOND			$W_{\mathbf{r}}$	MIS	2. Date of Death Month MAY	Day Year 200	7 12 -
Examir Funeral Director	er	4a. Facility Name (If not institution, give stre JOHNS HOPLINS BAY VIE 5. Social Security Number 6. Sex	a	NER it birthday) Yrs.	4b. City, Town, or I if Under 1 Year Months Days	ALTIMON If Under 24 Hrs.	8. Date of Birth (Month, Day, Sept 9,	4c. County of De. Year) 1924 Per	ath rthplace (State or Foreign country) nnsylvania
ס		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th the Mau or 28e-f	irector	MD Baltimore 10e. Street and Number		Bali	10f. Zip Code		10	Og. Citizen of What (
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or items 23a or 28e-f show singly joury or other traumatic event, the Medical Examinar must be notified a sonce.	by Funeral Director	1809 Kitty Hawk Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X pivorced	ad Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	212: Was Decedent of His if Yes, specify Cubar		cify Yes or No- Rican, etc.)	USA 14. Race - An Black, Wh Specify: W	ite, etc.
within 72 hou piene. r then "netural the Medical E	Completed t	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ion	(Give life. L	tent's Usual Occupa kind of work done di DO NOT use retired) homemaker	uring most of workin	99	own home	s/Industry
id be filed ental Hyg ked othe Ic event,	o Be C	17. Father's Name (First, Middle, Last) Charles Bertin				18. Mother's Name Kati	(First, Middle, M Le Morat		
12 should hand Mark	F	19a. Informant's Name/Relationship (Type						City or Town, State	
Definition of health moortent: Pages 1 and Department of Health mportent: If Item 2 and Injury or other 1		Bonita Patrick/daug 20a. Method of Disposition 1 Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	20b. Pla	ce of Dispo netery, cren	sition (Name of natory or other place) 	ate	ean View 20c. Location - City (or Town, State
Depermit Depermit Importan		21. Signature of Funeral Skryice Licensee Ronald S. W.	MIL	Ва	ltimore.	MD 21201		Baltimore	Street
Physician /Medical		23a. Part . Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Cause on each line. PLEUMONI Due to (or as a conseque	A-					Onset and Death
eath certificate be executed with certificate be executed with the estimation and managed for use as the burial-transit of	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	venye Puz	MONANY	DISEA	St	20 YEARS
. 0 00	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
_ <u>₹</u> _ <u>₽</u> _ ₽	Ď	Part II. Other significant conditions control	ibuting to death but not result	ting in the u	nderlying cause give	n in Part I.	23e. Did tol		to the cause of death? Probably 4 □Unknown
The law ete has b	Completed						24a. Was a autops perforr	y prior t med2 death	autopsy findings available o completion of cause of ? es 2 \sum No
Physician: The rithis certificete	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	spital:	R/Outpatier	nt 3 DOA Othe	26. Place of Death		ence 6 Other (S	pecify)
ending Physiath. or: After this he funeral di		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	res 2 □No		ow injury occurred	
Ital or Attending is after death.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or Town	n, State)	Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aliel completely filled in by the fune	Medical	(Check only 2 Medical Examine one)	cien: To the best of my know ir: On the basis of examination and manner stated.	ledge, deat on and/or in	vestigation, in my or	pinion, death occurr	ed at the time, d	ate and place, and o	lue to the cause(s)
To 1 To 1	2	29b. Signature and title of certifier Para bol Trobi	nedira Do	ofer	29c. License	- QOO	F	Pad. Date signed (Mo	2007
		30. Name and address of person who com PARIZAD TONASI, 4	pleted cause of death (Item	23a) (Type,	Print)	DALTIMO	ri, mo	Mycus	21224
St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 2 1 2007	9 40 EASTER 32 Registrar's Signatu	ire	well.		,	·	

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	Dhyoisi	0.00	1. Decedent's Name (First, Middle, Las	t)							2. Date of Deat Month	h Day	Year	3. Time of Death	
	Physici /Medio		Beverly Ann Werner May 4, 20							7		7:23 PM M			
1	Examir	er	4a. Facility Name (If not institution, give	street and numb	oer)		_		Location of	of Death		4c. County	ford		
			301 Trimble Road 5. Social Security Number 6. Se	ex 7	. Age (In yrs. I	ast birthdav)	J O P	•	If Under	24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign	
	Funeral Director			□M 2∏F	67	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Feb 17,	1940	Cou	ntry) Land	
	D _		Usual Residence of Decedent											10d. Inside City Limits	
	show	7	De MD Harford Joppa										1 ☐ Yes 2√ No		
	28a-f	Director	10e. Street and Number	LOLU		Joppa	10f. Zip	Code			1	0g. Citizen of	What Cou		
	a or		301 Trimble Roa	d			70 2	0000	2	21085			USA	,	
	72 hours after death with the Maryland Instural, or items 23a or 28a-f show dical Examinal must be indified at	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13.	Vas Deced	lent of H	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		ce - Ameri	can Indian,	
9	or its	/Fui	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	. ⊠ No		1 ☐ Yes	_	Specify:	i, i deito	riloari, oto.,		^{fy:} whi		
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212	within liene.	E O	Elementary/Secondary (0-12)								APG				
ğ	be filed stal Hygi d other	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle, I	Maiden Sumai	me)		
/lai	should band Ments marked	ToE	Hugh Calvert C							Mar	Ann Ba	.ker			
Maryland	2 sho and is mu	8	19a. Informant's Name/Relationship (-				d Route Number				
	of Health a litem 27 is other tran		Laurie Werner/dam 20a. Method of Disposition	ughter	20b. P	102 lace of Dispo			venue		re de G	race. N 20c. Location			
nor	ages nt of l t: if its	1	1 Burial 2 Cremation 3	//	tate C	emetery, crei	natory or o	ther plac	:ө)				•		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic avent, the Madical Examinating must be rediffied at once.	- 8	4 Donation 5 Mother (Specification of Funeral Service Licer Ronal Service Serv			22	. Name an	d Addres	ss of Facilit	ty					
Ba	Ped Per Per Per Per Per Per Per Per Per Per		Sens !	mill	rector	S t Ba	ate A Itimo	nato re.	omy B MD	oard 2120	655 W.	Baltim	ore S	Street	
	Physician		23a. Part I. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease of condition	plications that ca one cause on ea	used the death	n. Do not ent	er the mod	e of dyin	1					Approximate Interval Between Onset and Death	
1.	/Medical		resulting in death)	a. Due to (o	r as a consequ	n (No eof)	uni	2	OLK	20n	anul 1				
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9	ifficate g phy as the	edic		<u> </u>											
Вох	leath certifica attending ph i for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna th 2 ☐ Fetal								ate of deliv	very Day Year	
	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown									l ly	Onti	Day (Bai	
P.0	law requires that the de as been signed by the . 2 should be detached								ntribute to the cause of death?						
ds,	signe d be	d by	Diale	ele nelle						1 🗆 Y	es 2 No	s 2 No 3 Probably 4 Nonknown			
cor	w requ	Completed	1-Acrise	11.	1.						24a. Was a	an 24b. Were autopsy findings available			
Re	The lavele has	dmo	N99410	Mythan						autopsy prior to completion of o					
tal	sician: T certificet rector, pi	0	25. Was case referred to medical						26. Place	e of Deat	1 ☐ Yes h (Check only or	2 No	1 1 1 1 1 1 1 1 1 1 1	200110	
Ž	\$.g ₹	To B	examiner? 1 ☐ Yes 2,500	Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatie	nt 3 DC	Oth Oth	ler: 4□Ni	ursing Ho	me 5 Resid	ence 6 🗆 Ot	ther (Spec	ufy)	
0	D e		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury				8c. Injur Wor			28d. Describe how injury occurred				
sio	Attending ir death, ector: Altei by the fune	catl	2 ☐ Accident investigatio	e One Olege	of laine. At he	ma form of	M factor		Yes 2	No	28f. Location (Street and Number or Rural Route Number,			ral Poute Number	
Division of Vital Records,	after of Al	Certification:	4 Homicide determined	28e. Place of building	of Injury - At ho g, etc. <i>(Specif</i>)	y)	reet, ractor	y, office			City or Tow		100, 0, 710	an mobile realmoer.	
_	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Example)	nysician: To the miner: On the ba and mann	sis of examina	wledge, deat tion and/or in	h occurred vestigation	at the tir , in my c	me, date ar opinion, dea	nd place, ath occur	and due to the ored at the time, or	ause(s) and n date and place	nanner as , and due	stated. to the cause(s)	
Service of the servic								License number 29d.				ed (Month	Day, Year)		
			>	VILL	2			1)20	215	29d. Date signed (Mont			62	
			30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)	10	ane-	la	ands	29000	M	D4028	
	St	ate	31. Date filed (Month, Day, Year)	07 2. Re	egistrar's Sign	ure	whis .								

			For State of Ma	aryiand		triment of H		_	_	474 ATA BOOK	1.0000	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	lilicate of t	Dealli	2. Date of De		0.	3. Time of Death	
	Physicia /Medic		Herbert Eugene Widmayer May 17, 2007								6:55 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Silver S	Location of Death			c. County of Deat		
		20	12006 Centerhill Street 5. Social Security Number 6. Sex 7. Ag	ast birthday)	If Under 1 Year		8. Date of Bir					
* 1	Funeral Director		577-26-3577 ¹ 反 ^{M 2□} F		82 Yrs.	Months Days	Hours Min.	Sept.	ıy, Yea.	r) Co	nington, DC	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
	a-f sh	ctor	Maryland Montgomery	Silv	er Spi	ring					1 □ Yes 2√∑ No	
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. C	citizen of What Co	ountry?	
	23a cust b	ral	12006 Centerhill Street			20902				ted State		
	r dea	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		3. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit		
2-0036	be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	WWI:	I.	1 □ Yes 2 ☑ No	Specify:			Specify:	Thite	
ည	72 hc 'natuı dical	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b.	Kind of Business/	Industry	
7	vithin ne. han " e Me	шb	Elementary/Secondary (0-12) College (1-4or 5	r ₅₊₎ Self Employed				P.	ompany			
7	Hygie Hygie ther th		10 17. Father's Name (First, Middle, Last)								ompany	
aŭ	e d a e	o Be	Charles F. Widmayer				Irma Bay	ynes		,		
Maryland 2	d 2 should be the the and Mental Ith and Mental Ith and marked or traumatic eve	^L	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St					or Town, State, 2	Zip Code)		
Š	S a s		Frances L. Widmayer / Wife		12006	Centerhi	.11 St., :	Silver	Spr:	ing, MD	20902	
ē,	ss 1 a of Hei		20a, Method of Disposition	20b. Pla	ace of Dispo	osition (Name of matory or other place	ce) May	20°,	20c.	Location - City or	Town, State	
Ē	Pages ment of B ant; If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			Crematorium	1 0	007	Bet	hesda, M	laryland	
Baltimore,	permit. Pages 1 and Department of Health Important; If Item 27 any Injury or other to once.		21. Signature of Funeral Home/Rockville, Inc. M00896 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-28									
r	4		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li							, , , , , , , , , , , , , , , , , , , ,	Approximate Interval Between	
	Physician		Immediate Cause I Tal								Onset and Death 2 months	
	/Medical		resulting in death) a. Lung Ga		ence of):							
	Examiner		Sequentially list conditions b.									
-	Pa tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a conseque	ence of):		2					
	ecute and -trans	Examiner	that initiated events resulting in death) Last C Due to (or as	a consequ	ence of:							
68760,	ificate be executed physician and sthe burial-transit											
89		edical										
Box	leath certifi attending I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth			∃Ectopic pregnanc	v			23d. Date of de		
O. E	The law requires that the death cert to has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown							Month Day Year		
<u> </u>	that the		Part II. Other significant conditions contributing to death b	ut not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute to	o the cause of death?	
Division or Vital Records, P.O.	w requires that the d been signed by the should be detached	ed by						1 🙀	Yes	2 □ No 3 □ P	robably 4 Unknown	
တ္တ	aw re is bee 2 sho	Completed						24a. Was	s an	24b. Were a	utopsy findings available completion of cause of	
ř	The lav ate has page 2	Com						perf 1∐ Yes	ormed?	death?	s 2 No	
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			Leu	26. Place of Dea	th (Check only	one)			
2	ohysi this c	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati		ER/Outpatie		4 □ Nursing H			6 □Other (Spe	ecify)	
n N	ding F	ion:	1 Natural 5 Pending (Month, Da	iy Year)	Injury	Wor	ryai rk? Yes 2 □ No	28d. Describe	now in	jury occurred		
S	or Attending Physician: after death. Director: After this certifica in by the funeral director, I	licat	3 Suicide 6 Could not be 28e. Place of in	jury - At hor	me, farm, st	reet, factory, office	100 2	28f. Location	(Street	and Number or R	lural Route Number,	
2	after after Dire	Certification:	4 ☐ Homicide determined building, e	tc. (Specify	1)			City or To	iwn, Sta	ate)		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best									
	the H nin 24 the Fi nplete	Medical	one) and manner s									
	To con	2	29b. Signature and title of certifier	\		29c. Licens D458				Date signed <i>(Mon</i> y 18, 20		
•	11,		1 out		00 \ 7				ria.	y 10, 20	· · · · · · · · · · · · · · · · · · ·	
1	10		30. Name and address of person who completed cause of				rillo Mo	ruland.	200	50		
,	Sta	ite	Leon C. Hwang, M.D., 1396 F 31. Date filed (Month, Day, Year) 32. Regist	rar'e Signat	ture		/IIIe, Ma	гатип	200.	JU		
	Regist		MAY 2 1 2007	Ester .	A. A	Carles						

Bradley Jonathan Abbuhl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2007 16390

		egistrar	Certific	ate of D	eam			eg. No.	3. Time of Death		
Physicia		Decedent's Name (First, Middle,Last)					2. Date of Dea Month	Day Year	1634 hrs		
Examir		Bradley Jona	than Abbuhl, Jr				May 4, 20	007	10041119		
		a. Facility Name (if not institution, give s	4b.	City, Town, or I	ocation of Death	4c. County of	Death				
		Union Hospital		İE	Elkton			Cecil			
				41. 45. 4	If Under 1 Year	If Under 24Hrs	8 Date of Bi	rth (MM/DD/YYYY)	Birthplace (State or		
Funeral	5	. Social Security Number 6. Sex	7. Age (In yrs. last bir		Months Days		_	Tar(Name DD) TTT	Foreign		
Director		215-77-9230 1 XM	2 F 0	Yrs.	5 6	110013		28, 2006	Country) Maryland		
	-	sual Residence of Decedent					THE VI				
any	_	0a. State 10b. County	10c. City, Town	n or Location					10d. Inside City Limits		
			E1kto	'n					1 Yes 2 X No		
and show nce,	5	Maryland Cecil	EIRCO					10g. Citizen of Wha	at Country?		
aryla aryla 8a-f	형	0e. Street and Number			Of. Zip Code						
or 2	Director	205 West Pulaski H	lighway, Room 17	/	21921			United S	itales		
ith th	## 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								- American Indian, Black,		
th w	- I	1 X Never Married 2 Married	Warried 2 Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.								
dea or it	11 1		1 Yes 2 X No		o	anee'h u		Specify:	White		
after ner	<u>a</u> _		Yes, Give Year r Dates:		es 2 _{XX} No		and dama	16b. Kind of Bus			
atur		15. Decedent's Education (Specify only	highest grade completed) 16a	 Decedent's during most 	Usual Occupat	ion (Give kind of DO NOT use re	work done tired)	100. Killa of Bus	silless/illustry		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	daning moon	. 0, ,, 0,, ,,,,,		,				
5-0036 Iled within 72 Hygiene. I other than	ᅙ	0		Not				None			
With Mer	등	17. Father's Name (First, Middle, Last)				18.Mother's Nam	e (First, Middle	, Maiden Surname)			
在 景表 2 4	9	Bradley Jonathan	Abbubl Sr		İ	Mary A	nn Thom	pson			
21215-0036 Juld be filed within 72 Mental Hygiene, marked other than ic event, the Medical	라			9b. Mailing A	ddress (Stree	et and Number or	Rural Route N	umber, City or Tow	n, State, Zip Code 1921		
AD 21 2 should h and Me 27 is ma matic ev	ř	19a. Informant's Name/Relationship (Tyr Bradley J. Abbunl	Sr / Hather						Elkton,Maryland		
	L	Mary Ann Thompson			on (Name of ce		Date		City or Town, State		
sees I and 2 shount of Health and Nt. If item 27 is not other traumatic	- 1	20a. Method of Disposition 1 X Burial 2 Cremation 3		atory or other	r place)	M.	ay				
othe		**	Ebene	ezer C	emetery	1	2, 2007	Rising S	Sun, Maryland		
ting true	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service License						uneral Ho			
Baltimore, permit. Pages I am Department of Heal Important: If iten injury or other tra	- 1	21. Signaturo							, Maryland21901		
	_	23a. Part I. Enter the disease, or complic	that saused the death. Do	not enter the	mode of dving	such as cardiac	or respiratory a	arrest, shock, or he	art Approximate Interval		
ysician	- 1	failure. List only one cause on each	n line.						Between Onset and Death		
Medical	- 1	Immediate Cause (Final disease a	Sudden unexplained	death i	n infanc	7					
Examiner			ue to (or as a consequence of):								
		Sequentially list conditions, b									
	횰	if any, leading to immediate D	ue to (or as a consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
. S =	ā	events resulting in death) Last	ue to (or as a consequence of):								
nd rans	삗	d									
exec	n/Medical	X UNPENDED	4#23a,27,28a-f, per	ME. 086	8 6/18/0	77 TT					
se be	필	IF FEMALE:	23c. If yes, outcome of pregnan		0, 0/10/(77_11		23d. Date of	f delivery		
376 ifical ig ph	튑	23b. Was decedent pregnant in the	1 Live birth		al death 3	Ectopic preg	nancy	Month	Day Year		
certi certi endin	<u>.e</u>	past 12 months?	4 Pregnant at time of death		er (Specify)			10			
cath for u	/Si	1 Yes 2 No 9 Unknown	g Unknown								
he d	Physicia	Part II. Other significant conditions	contributing to death but not resul	Iting in the un	derlying cause	given in Part I.	23e. Di	d tobacco use cont	ribute to the cause of death?		
that detay	þ		•				1	Yes 2 ✔ No 3	Probably 4 Unknown		
ires ires sign	ᄝ						24a. W	as an 24h	Were autopsy findings available		
request personal pers	Completed						_ au	itopsy	prior to completion of cause of		
CO law las e 2 s	립							erformed? es 2 No	death? 1 ✔ Yes 2 No		
Re The pag	ខ្ល				oc Dia	ce of Death (Che					
ian: ian: ctor,	Be	25. Was case referred to medical examiner?	ospital:			Othor		Residence 6	Other:		
ysic dire	0	1 ✔ Yes 2 No	I IIIpatient 2 🛡 Ci				sing Home 5				
of ig Ph fier neral	T:T	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	3b. Time of In	′ ′ _	jury at Work?	28d. Descri	be how injury occur	reg		
ndin T. A	io E	1 Natural 5 Pending	Fnd 5/4/2007 F	and 4:05	om 1_	Yes 2 X No	unk				
Sic Atte ecto by tl	ca	2 Accident Investigation 3 Suicide 6 X Could not be	28e Place of Injury - At home			building, etc.			ber or Rural Route Number, City		
afe in in in in in in in in in in in in in	Certification:	determined	oe					n, State) Pullodei Hu	v. Fikton, MD		
spita cours reral	S	4 Homicide				I to and place			,		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and repletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>8</u>	(Check dill)	an: To the best of my knowledge, On the basis of examination and/	death occurr	ed at the time,	date and place, a on ideath occurre	and due to the d ad at the time, d	late and place, and	due to the cause(s)		
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Medical	2	and manner stated.	or investigati							
To To Con	₹ E	29b. Signature and tale of certifier			29c. Lice	nse number			ned (Month, Day, Year)		
		1 1//			0.0	C.M.E.		May 5, 20	007		
		///	ampleted pougo of death (from 00	39)							
4	1	30. Name and address of person who of Mary G. Ripple MD. Dep	outy Chief Medical Exami	ner 111	Penn Stre	et, Baltimore	MD 21201				
W.						,					
-4		31. Date filed (Month, Day, Year)	32. Registrar's Signature								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Loussine Leon 6, 2007 а М Assarian 3:40 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√□ F Yrs. 63 Director 214-11-0985 March 18, 1944 Lebanon Usual Residence of Decedent 72 hours after death with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Montgomery Montgomery Village 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 18724 Walker's Choice Road, #4 20886 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. SpecifyWhite 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Lidia Dekermenjian Leon Assarian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), MD 19a. Informant's Name/Relationship (Type. Print) 20886 Village 18724 Walker's Choice Road, #4, Montgomery Maria Assarian/ Sister other t permit. Pages 1 an Department of Heali Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 ☐Removal from State May Gate of Heaven Cemetery Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee ren 500 University Blvd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complice shock, or heart failure. List only one ion that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** MULTI 08 GAN /Medical Due to (or as a consequence of): Examiner VATUCE Euguentially fiel our differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed -1 VER and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cease. 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

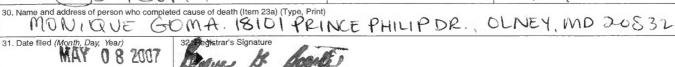
1 □Yes 2 □ No 24a. Was an has autopsy page 2 3 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Yes 2 No 2 Accident hours after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a 2

> State Registrar

31. Date filed (Month, Day, Year) 08

29b. Signature and title of certifier



M.D



29c. License number

D0065024

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year $May^{Month} 3,2007$ **Physician** Teresa Andrews 6:09a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1Mpnth 13/1955 1 □ M 2 🔼 F 51 Brooklyn, NY 081-46-0391 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Silver Spring MD Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 USA 12325 New Hampshire Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbur Andrews Sarah Rice 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 Javonna Andrews/Daughter 7611 Swan Terrace Hyattsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 № Burial 2 □ Cremation 3 🖺 Removal from State Forest Green Mem.Pk 5/11/07 Morganville, N.J. 4 ☐ Donation 5 ☐ Other (Specify) PHINTP ADSRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiopulmonary arrest /Medical Due to (or as a consequence of) **Examiner** Myocardial infarction Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Lar Attending Physician: The law requires that the death certificate be executed after death. Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical End stage renal disease 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1∐ Yes 2 No 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 X ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46529 May 4,2007 MD30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor C.Oneyejiaka MD 7325 Hanover Parkway Greenbelt, Md 20770 31. Date filed (Month, Day, Year) egistrar's Signature State MAY 0 8 2007 Registrar

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		For	State of Maryl				Mental Hy	giene,	16393		
		1 - State Registrar		Ce	rtificate of	Death		Reg. No.	10000		
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S 1 a		20a. Method of Disposition	20	b. Place of Disp	osition (Name of matory or other place	ce)	Date	20c. Location - City or			
Page Bent c nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec	□Removal from State ify) //	-	ie Method	a	16,2007	Mt. Savag	e, Maryland		
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tune fune	tior	1 Natural 5 Pending 2 Accident investigated	(Month, Day Yea	r) Injury	Wor	k? Yes 2∐No	28d. Describe how injury occurred				
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To the Hospital or Attanding Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medicel Exa	miner: On the basis of exam and manner stated.	nination and/or in	ivestigation, in my o	pinion, death occ	urred at the time, o	date and place, and due	to the cause(s)		
To th within To th	ž	29b. Signature and fittle of certifier	0 00		29c. Licens			29d. Date signed (Mon			
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ب.		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)		<u>-</u>	1	-)		
hds		A Lag Ahma		Kent 1	Ave. Suit	e 102, C	umberl	and, MD	21502		
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	7						
Regist	ar	MAY T 9	200/	, M. 1	Augusto.						

07-03664 Ralph Bostion Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 16394 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ May 13, 2007 RALPH THOMAS BOSTTON 0729 hrs dical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital - Shock Trauma Baltimore 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country Maryland Months Days Hours Min 220-26-7350 Director 05/21/1931 75 1 X M 2 Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits Maryland Carroll County Taneytown 1X Yes 2 No 23a or 28a-f show notified at once. nours after death with the Maryland Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 30 George Street 21787 United States Funeral 14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 X Yes 9 If Yes, Give Year 1949–1953 Divorced 1 Yes 2 X No specify: Specify: White Widowed 'natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) mit. Pages 1 and 2 should be filed within 72 hour urtment of Health and Mental Hygiene.
rannt: If item 27 is marked or other trans. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) truck driver overland transport 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Bostion Mary Alice Grimm Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Sherry Bostion / wife 30 George Street Taneytown, Maryland 21787 May 15, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 XCremation 3 Removal from State Smithsburg, MAryland Smithsburg Crematorium permit. Page
Department of
Important:
injury or oth 2007 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Line nsee Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 2178 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. 'Medical Death a. Multiple Injuries Immediate Cause (Final disease _xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical g physician a the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d, Date of delivery Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes Nο To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Hospital: 1 Inpatient Nursing Home 5 ER/Outpatient 3 Residence 6 this 1 🗸 Yes No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Subject was in front of his van when his ven May 13, 2007 0140 hrs 1 Natural 1 ✓ Yes 2 No Pending the 1 was struck by a car from behind 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 320 College View Blvd., Westminster, MD determined (Specify) Local Street Homicide completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 14, 2007 O.C.M.E. m 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registrar's Signatur

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 14 2007 02 20 MAY BRITTEN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ALLEGANY CUMBERLAND MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) Apr 3, 1955 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days Hours МD 1 ☑ M 2 □ F 52 219-76-1862 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1√Yes 2□No Cumberland Allegany MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 409 Grand Avenue 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 🗆 Yes 2 🗆 📉 o Specify: Specify: white Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Britten Dorothy E. Alfred W. Britten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Cumberland 409 Grand Avenue Cheryl Britten sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5/18/2007 MD 1 → Burial 2 □ Cremation 3 □ Removal from State Cumberland Sunset Memorial Park 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Luneral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death e of delivery Day ıth ibute to the cause of death?

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Department of Health rangoriant: if terrang any injury rangoriant: if terrang any injury rangoriant. Physician /Medical Examiner

Physician

Examiner

Funeral

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should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

10a. State

certificate be execute

Examiner attending physician and for use as the burial-trar detached signed by t ficate has been sig r, page 2 should b funeral director, this s after death filled in by

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

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23a Part . Enter the disease, or co shock, or heart failure. List or	omplications that caused the death. Do not enter the mode of dying, such as cardiac only one cause on each line.			Interv	oximate al Between t and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY FAILURE Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PLEURAL EFFUSION Due to (or as a consequence of): C. Due to (or as a consequence of): d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf pregnancy 1		23d. Date of de Month	elivery Day	Year
	ns contributing to death but not resulting in the underlying cause given in Part I. ${ m ER}$		co use contribute t		
		24a. Was an autopsy performed	l? d <u>ea</u> th?	autopsy fir completion	ndings available on of cause of No
OF Was asso referred to medical	26. Place of Dea	th (Check only one)			

Completed by Physician/Medical Be Certification: To Medical

2 No 1 🗌 Yes

27. Manner of Death 5 Pending

1 X Natural investigation 2 Accident 6 Could not be determined 3☐ Suicide 4 THomicide

1 Kinpatient 28a. Date of Injury (Month, Day Year)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie DESCRI

29a. Certifier

and manner stated.

29c. License number D31875

29d. Date signed (Month, Day, Year) MAY 🔫 , 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

904 SETON DRIVE ROBERT WELIK, M.D.

31. Date filed (Month, Day, Year)

MAY 2 1 2007



CUMBERLAND, MD 21502

State

Registrar

within 24 hours at To the Funeral D completely filled i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day \mathbf{P}^{M} **Physician** 5:52 MAY 5, 2007 BIRCH LOTTIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days **Funeral** Hours Min. 97 POLAND 055-10-3210 Vrs 09/26/1909 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MONTGOMERY VILLAGE MARYLAND MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 20886 19310 CLUB HOUSE ROAD #406 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
nt: If item 27 Is marked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married WHITE 1 ☐ Yes 2 ☐XNo Specify Specify: Baltimore, Maryland 21215-0036 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be "IINKNOWN" MAX ETTINGER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8005 EXODUS DRIVE, GAITHERSBURG, MARYLAND 20882 FRANCES LOWE/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State LONG ISLAND, NEW YORK NEW MONTEFIORE CEMET. 05/10/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 of Funeral Service Licensee 21. Signatur Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myo card **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23d. Date of delivery for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 | Fetal death 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No the 9 Tilnknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s has 2 No 1□ Yes this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28d Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Injury or Attending 5 Pending 1 Natural М 1 ☐ Yes 2 ☐ No investigation 2 Accident death within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

To the

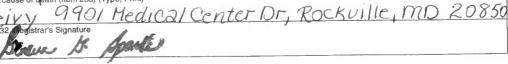
State Registrar

31. Date filed (Month 0 8 2007

Mai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

McGr



ORIGINAL

May

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Baltimore, Maryland 21215-0036 Physici /Medi Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funarial Director: After this certificate has been signed by the attending physician and commission filled in by the timenal director mane? Should be detached for use as the builds-transit Division or Vital Records, P.O. Box 68760,

	1	For State Registrar			ı Marylan		rtificate of	Death		ene g. No. 20	07	16397
Physician /Medical		1. Decedent's Name Mary		st)	Lou		Bucy		2. Date of Death Month	13 2	Year 7	3. Time of Death 12: 42 AM
Examiner		4a. Facility Name (/	f not institution, giv	e street and nur	mber)		4b. City, Town, o	r Location of Death	,	4c. County		
	47		ires Aver					Vale			Alle	
Funeral Director		5. Social Security N 214-32-3	412	ex □M 2∏XF	7. Age (In yrs. 72	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/27/19		9. Birthpl Count Mary	
>	- 1-	Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	y, Town or L	ocation				10	Od. Inside City Limits
or 28a-f sho be notified al		MD		egany			LaVale					1 ☐ Yes 2 🏋 No
23a or 24 ust be no		10e. Street and Nu	weires Av	enue			10f. Zip Code	21502	10	g. Citizen of V	Vhat Count USA	try?
Department of Health and Mental Hygiene "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merkal Examiner must be notified at once. To Be Completed by Funeral Director	2	11. Marital Status 1	ried 2[X] Married 4 □ Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or D	2 [XNo /e	.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America k, White, e	
ygiene. ler than "natur: t, the Me Ical E		(Spec	15. Decedent's Ed	lucation ide completed)		16a. Dece	edent's Usual Occup kind of work done DO NOT use retire	oation during most of work d)	ing 1	6b. Kind of Bu	isiness/Ind	ustry
than the Me		Elementary/Seco	ondary (0-12)	College (1	-4or 5+)		Homemaker	u)		Но	me	
Hyg ent, t		17. Father's Name	(First, Middle, Last,)		1		18. Mother's Name	e (First, Middle, M			
Mental H arked ott attc ever		Virgil		Willia	am	Twi	gg	Doris	Loui	se	Ger	bing
s mai	1	19a. Informant's N	ame/Relationship (Type. Print)		19b. Mail	ing Address (Street	and Number or Run	al Route Number,	City or Town,	State, Zip	Code)
n 27 In ealth	1		e Bucy /	husband				enue, LaV			2150	
F ite		20a. Method of Disp 1 ☐ Burial 2	position ∭Cremation 3 □	Removal from		Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)		0c. Location -	City or Tov	wn, State
tment tant: jury		4 □ Donation	5 Other (Specif	y)	Cur		nd Cremat	• ,	I .	Cumber		
Depar Impor any in		21. Signature of Fu	underal Service Licer	Cela	m	2		ess of Facility Ada tur Street				1502 P.A.
nysician Medical xaminer		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List only (Final	one cause on e	aused the deat ach line.	90 Y		ng, such as cardiac			0	Approximate Interval Between Onset and Death
physician and its the burial-transit edical Examiner		Sequentially list co if any, leading to in- cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	erlying injury	C	or as a conseq	,						
ing phy as th		IF FEMALE:								П		
d by the attendinetached for use	1	23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live b	come pf pregna pirth 2 Peta pant at time of d	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Dat Mor	e of deliver	ry Day Year
en signed bould be deta		Part II. Other signi	ficant conditions of	contributing to de	eath but not res	ulting in the t	underlying cause giv	ven in Part I.	23e. Did toba			e cause of death?
cate has been spould page 2 should									24a. Was an autopsy perform 1□ Yes 2	ed?	prior to com leath?	psy findings available apletion of cause of
certific ector,		25. Was case refer examiner?		Hospital:			104		h (Check only one			
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical	P	1 ☐ Yes 2 ☐ 27. Mann of Deat 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide		28a. Date (Moni	th, Day Year) of injury - At ho	28b. Time of Injury	of 28c. Inju	ry at rk?	28d. Describe how 28f. Location (Street	v injury occurr	ed	
neral Dir filled in		29a. Certifier			ng, etc. (Specif		th occurred at the ti	me, date and place,	and due to the cal		nner as sta	ated.
thin 24 hou the Fune suppletely fi		(Check only one) 29b. Signature and		niner: On the b				opinion, death occur	red at the time, da		and due to	the cause(s)
5		1	Mag	MI	VM)		D	2218	1 p	TAY 1	4,0	007
nes	-	30. Name and add	ress of person who L. Wagone					r., Cumbe	rland, M	D 21502	2	
State Registrar		31. Date filed (Mon		-	egistrar's Signa	ature	1					

			For State Registrar	State of M	/laryland		artment of F rtificate of	lealth and N <i>Death</i>		giene Reg. No.2 (107	1639	18
	* **		Decedent's Name (First, Middle, La	st)					2. Date of De	ath	, ,	3. Time of Dea	ath
П	Physici		M	ARY VIRO	GINIA		BENNETT		Month 05	Day 15	O7	1125	M
	/Medio		4a. Facility Name (If not institution, give					r Location of Death			nty of Death		-
			WMHS BRADDOCK C	AMPUS			CUMBER	LAND		ALL	EGANY		
3	Funeral		Social Security Number 6. 8		Age (In yrs. las	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birthp	place (State or For	reign
£:	Director		217-28-0293	□M 2∏F	75	Yrs.			04/03/			yĺand	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1.	10d. Inside City Lir	mits
	Aaryk f sho ed at	ō	MD Alleg	anv			umberlan	d				1 X]Yes 2□	
	the N 28a- notifi	Director	10e. Street and Number		1		10f. Zip Code			10g. Citizen o	of What Cou	ntrv?	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		12 E. Oldtown	Road				21502			USA	,	
	ms 2	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	. 13. V	Vas Decedent of I-	lispanic Origin? (Sp	pecify Yes or No		lace - Americ		
9	after or Ite mine	Full	1 ☐ Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give			r Yes, specify Cub I □ Yes 2 🛛 No	an, Mexican, Puerto Specify:	o Hican, etc.)		lack, White,	etc.	
93	ours iral",	d by	3 Widowed 4 Divorced	Year or Dates						Spec	city:	White	
V	72 h "natu	Completed	15. Decedent's E (Specify only highest gr	fucation ide completed)		(Give	lent's Usual Occup kind of work done	during most of work	king	16b. Kind of	Business/In	dustry	
12	within	mp	Elementary/Secondary (0-12)	College (1-4or	r 5+)		00 NOT use retire. Homemake	,		ш	ome		ĺ
d 2	filled Hygir ther int, th		17. Father's Name (First, Middle, Last)			Homemake	18. Mother's Nam	ne (First, Middle,				-
au	ild be i fental l rked o	To Be	Samuel	Leo	Vo	orhee	S	Ida	Pe	earl	Sł	nipley	
Maryland 21215-0036	should ind Men is marke umatic	-	19a. Informant's Name/Relationship	Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City or Tow			
	and 2 ealth a n 27 is ier trai		Robert W. Bennett	/ husbar	nd	12 E.	Oldtown	Road, Cu	umberlan	nd, MD	21502	2	
e,			20a. Method of Disposition	ID	COL	ce of Dispos	sition (Name of natory or other place	1	Date	20c. Location			
Ĕ	Pages nent of I int: If Ite		1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Cont		e	•		cky Gap	05/18/2	2007	Flints	stone, MI	5
altimore,	permit. Pages Department of Important: If II any Injury or o		21. Signatur of Funeral Service Lice	asee				ss of Facility Ac			neral	Home, P.	.A.
<u> </u>	8 9 E 8 9		* taket (" ach	w			ur Street			MD 2	21502	
۲			23a. Part1. Enter the disease, or com shock, or heart failure. List only									Approximate Interval Between	,
78	Physician		Immediate Cause (Final disease or condition	NON S	MALL	CEL	LE CAN	ICER	OF L	UNG.		Onset and Death	1
	/Medical Examiner		resulting in death)	Due to (or a									
	Lxamme;	<u>_</u>	Sequentially list conditions,	t. A IKI &	S a conseque		CILLA	1107					
	ted 1sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a conseque	ence or):							
	xecur and al-trar	Examine	that initiated events resulting in death) Last	c Due to (or a	is a conseque	ence of):					-		
8760,	ficate be executed physician and sthe burial-transit	dical		d									
89	ificate g phy.	edic		. U.									
ŏ	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			l=1			23d. [Date of delive	ery	
. Box	deatl e atte	icia	in the past 12 months? 1 □ Yes 2 ★No	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pregnanc Other <i>(specify)</i> _	y 		ľ	Month	Day Year	
<u>о</u>	at the by th tache	hys	9 Unknown	9□Unknown					- 10				-
s,	n requires that the de been signed by the s should be detached	by F	Part II. Other significant conditions	_	but not result	ing in the un	iderlying cause giv	en in Part I.				he cause of death	
Vital Records,	equin sen si ould I	ted.	Hypertcus1	50					10	Yes 2 No	3 ☐ Prob	oably 4 ∐Unkno	own
မင္ပ	law r las be 2 sh	ple							24a. Was autor		b. Were auto	psy findings availa	able of
<u>~</u>		Completed							perfo	rmed? 2 No	death? 1 □ Yes	•	
/Ita	cian: ertific	Be (25. Was case referred to medical examiner?	11			Tau.	26. Place of Deat	th (Check only o	ne)			
2	> .⊍ 0	၉	1 ☐ Yes 2 No	Hospital: 1' npat		R/Outpatien		4 □ Nursing H	ome 5 Resid			fy)	
2	ling I	. <u>i</u>	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □		28d. Describe l	now injury occ	urred		
<u>s</u>	ttenc death stor: the	icat	2 Accident investigatio 3 Suicide 6 Could not b		niun, At hom	e farm etre	eet, factory, office	Yes 2□No	28f Loanting /	Etroot and Nur	mhor or Pur	al Route Number,	-
Division or	after a	Certification:	4 ☐ Homicide determined		etc. (Specify)	io, iaiii, suc	ot, lactory, office		City or Tov	vn, State)	Tiber of Aura	a noute Namber,	
	spital ours neral filled		29a. Certifier 1 Certifying PI	ysician: To the bes	at of my knowl	ledge, death	occurred at the til	me, date and place,	, and due to the	cause(s) and	manner as s	stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	(Check only 2 Medical Example)	niner: On the basis and manners	of examination	on and/or inv	estigation, in my o	opinion, death occur	rred at the time,	date and plac	e, and due to	o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)	
	3		N.5	AISRANI	MI		DON	64167		511	5/07	}	
	-		30. Name and address of person who		death (Item 2	23a) (Type, I	Print)						
	nds		Noshin Qai	<u> </u>	n.D.	47	Virginia	a Avenu	e, Cur	mberlo	and I	MD 215	202
	Sta		31. Date filed (Month, Day, Year)	401	trar's Signatu	re	218 1			,	1		
	Registr	ar	121 10 21	UI	20 10	A STATE OF THE PARTY OF THE PAR	Section Control						

Please Type or Print in Black Indelible Jpk. Ensure All Copies Are Legible.

AMEND TTEM#2 per PHYS., G8675/23/07, WS

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007ear SECKWITH **Physician** 3:25 A M MAI -2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 406 BROad WAY FREDERICK NEDERUL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)
57 Yrs. 8. Date of Birth (Month, Day,) Birthplace (State or Foreign Country) **Funeral** Year) 216-54-8292 1 M 2 € F MO. Eb. Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MEDERICK IXD. MEDERICK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 BROadwAr 21701 U.S Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospital Elementary/Secondary (0-12) College (1-4or 5+) AIDE 12th s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ACHEL David Holland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 193 Willow Creek Dr. Gaithersburg Md. 20887 Maurice Beckwith (hus permit. Pages 1 ar. Department of Heal Important: If item 2 any Injury or other? 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fairview Cenety May 10, 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Facility GARY L. ROLLINS FUNERA NONE 110W. South ST. FREDERICK MB. 21701 1 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER METRSTATIC COLON YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-tran and Due to (or as a consequence of): sete has reen signed by the attending physician page 2 should be detached for use as the burian Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Attending Physician: he law 24a. Was an autopsy performed? this certifice te 1∐ Yes 2 100 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director; A
filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7 TH MD 2007 D0056314 30. Name and Indress of person who completed cause of death (Item 23a) (Type, Print) 3 JUHNSON DRIVE, THOMAS PREDORICK, MD 21702 46B GEORGE 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

		1 - For State Registrar	State of	Marylar		artment <i>rtificate</i>			and M	1ental	Hygiei Rag.	60	07	16401
Physici /Medi		Decedent's Name (First, Middle, CHARLES	Last) BAKER							2. Date of Month	ח	Day	Year 2007	3. Time of Death
Examir		4a. Facility Name (If not institution, s					own, or	Location o	of Death				ty of Death	R COUNTY
Funeral Director		221-28-8519	5. Sex 7. 1 X M 2 □ F	Age (In yrs. 62	last birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	24 Hrs. Min.	8. Date of (Montile DEC	of Birth h. Day, Ye 11,19	944	9. Birthp Cour MARY	place (State or Foreigntry) LAND
a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County DELAWARE SUSSE.	X COUNTY		y, Town or Lo	cation							1	0d. Inside City Limits
with the	Director	10e. Street and Number				10f. Zip (f What Cour	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Imprortent: if Item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other traumatic event, I'm Medical Examinations invittled at 2006.	ted by Funeral	11. Marital Status 1 Never Married 2 Marrier 3 Widowed 4 Divorced	If Yes, Give Year or Date	es? □No	67	Mas Decede f Yes, specif Yes 2. dent's Usual	No Occupa	Specify:			or No-	14. Ra Bla Spec	D STATE ace - Americ ack, White, ify: WHI Business/Inc	ean Indian, etc.
d within 7 giene. er then "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work DO NOT use ER/OPE	retired)) -	t of worki	ng	М	OBIL	Е НОМЕ	SETUP
should be filed nd Mental Hygi marked other umatic event,	To Be (17. Father's Name (First, Middle, La JOHN BAKER	ast)						r's Name		SEXT		ame)	
and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship LINDA BAKER	o (Type, Print)									-	n, State, Zip 19939	
Pages 1 a nent of Hei nnt: If Item rry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		ate c	Place of Dispo emetery, crer	sition (Name natory or oth	e of ner place	9)	C	ate	20c.	Location	- City or To	
permit. P Departme Importen any injur		21. Signature of Funeral Service Lic			REMATOR 22 1361 WA	. Name and	Address	s of Facility	у				R, DE	
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	Completed by	Past Smiking	, 065es	ssive 1	Comfic	lsive	d	word	22	a	Was an autopsy performed a	?	prior to con death?	osy findings available pletion of cause of 2 No
/sicien: Th s certificate director, peg	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inp	ationt 2	ER/Outpatien	t 3 DOA	Other	26. Place				a []0.	her <i>(Specif</i> y	
ling Ph n. After th funeral	\vdash	27. Manner of Death 1 Natural 2 Accident 5 Pending investigat	28a. Date of I (Month,		28b. Time of Injury		. Injury Work	at	2	ne b∐f 28d. Descr	ribe how in	iury occu	ner (<i>Specif</i> y irred	9
tal or Att rs after de et Directe ed in by t	Certification;	3 ☐ Suicide 6 ☐ Could not determine	a 286. Place of	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory,	office		2		on (Street r Town, Sta		iber or Rurai	l Route Number,
To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Cartifying (Check only one)	Physician: To the be aminer: On the basi and manner	s of examinat	wledge, death tion and/or inv	occurred at restigation, in	the time n my opi	e, date and inion, death	place, a	and due to ad at the ti	the cause me, date a	(s) and m ind place,	nanner as sta , and due to	ated. the cause(s)
vith To T	2	29b. Signature and title of certifier play	*				License	_	5			_	ed (Month, L	* * * * * * * * * * * * * * * * * * * *
BAati		30. Name and address of person wh	io completed cause of	of death (Item	23a) (Type, I	Print)	- D	, 0	am.	hrist	90	MD	211	2007
Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8	100	istrar's Signat	ture A	recti			1001	5	- 11		2.0	* 440

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician G May 4, 2007 Bebee /Medical unknown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 6437 Mary Jane Drive Salisbury
If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ፟ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Yrs. Director 86 381-14-3312 20, 1921 Michigan Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or items 23s or 28e-f show the Medical Executes must be confired at 1 Yes 2 No Director MD Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6437 Mary Jane Drive 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 □ No 1940 – If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Iter any njury or other treumatic event, ir a Medical Exacutation on. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Matthew Bebee Winifred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris E. Bebee- Wife 6437 Mary Jane Drive Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5/7/2007 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E Main Street Salisbury, MD 21804 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tens asclevatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examine attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part In Other significant conditions contributing to death but not resulting in the underlying cause given in Part 4. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check only ne Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how infury occurred Certification: 1 Natural 5 Pending after death.

Director: Aft d in by the fun 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours aft To the Funerel D completely filled in 29a. Certifier 1 Lestrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Hospitel or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Cockeymo 31. Date filed (Month, Day, Year)

30. Na and address of person who completed cause of death (Item 23a) (Type, Print)

1+1 mirluid 1346 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

D0051674

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Sta	te of Maryland / Department of Health and Mental Hygiene 🛛 🗍

			1 - For State Registrar	State of Maryta		rtificate of			Reg. No.	_ 0 0 7	10902
П	Physici	an	Decedent's Name (First, Middle, Last	11)				2. Date of De Month	Day	Year	3. Time of Death
	/Medi		Frederick Way			· · · · · · · · · · · · · · · · · · ·		May 1			654 P M
7	Examir	er	4a. Facility Name (If not institution, give				or Location of Deat	h	4c. 0	County of Death	
			702 Morris Ave.,				ndsville			Garret	
	Funeral Director		210-00-1082	ex 7. Age (In y	rs. last birthday Yrs.	Months Days			1953	Cour	olace (State or Foreign otry) t Virginia
	yland		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocalion				1	0d. Inside City Limits
	Ba-fet	ctor	MD Garre	ett		Friends	ville				1 X Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number 702 Morris Ave.,	Ant #203		10f. Zip Code	21531		10g. Citiz	en of What Cour USA	ntry?
	death me 23	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	o- 1	4. Race - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Exprint at must be notified at ance.	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 💢 No		to Rican, etc.)		Black, White, Specify:	_{elc.} Vhite
15-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retir	during most of wo	rking	16b. Kin	d of Business/Inc	dustry
12	within iene. then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	1110.	Disab				None	
9	Hygi Hygi other	ပိ	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden S	<u> </u>	
'lan	Aental Aental rked	To Be	Walter Ellswo	orth Bake	r		Gertru	de S	Janet	te W	lalters
Maryland	2 short and N ie ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ng Address (Stree	at and Number or Ru	ural Route Numb	er, City or	Town, State, Zip	Code)
	and ealth m 27	ļ	Linda Hefner/ Sist				te Oak Ro				
Baltimore,	Pages 1 nent of H ant: if ite ary or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Hemoval from State	_	osition (Name of matory or other plants	ace) 5/	Date 15/07		ation - City or To	
Itin	iit. Partmer artmer artant injury		4 □Donation 5 □ Other (Specify 21. Signature of Fune all Service) □ Con			rematory 2. Name and Addr				gantown,	
Ba	Depa Impo any ir		> Bull 18	Vous	1		uneral Ho		S. So cland	econd St , MD 21	.550
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	eath. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Hypertens	ive Art	erioscle:	rotic Car	diovascu	ılar 1	Disease	Onset and Death Years
1	/Medical Examiner		resulting in death)	Due to (or as a cons							
ı		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):						
	uted d ansit	fedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-	-,						
ó	exection and rial-tra	Еха	resulting in death) Last	Due to (or as a cons	equence of):						
68760,	death certificate be executed e ettending physicien and and for use as the burial-transit	Ical	(d							
	e as t		IF FEMALE:								
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 F	etal death 3	Ectopic pregnan	су		23	3d. Date of delive Month	Day Year
P.O.	ires thet the death cer signed by the ettendir d be detached for use	Physician/A	1 Yes 2 No 9 Unknown	4☐Pregnant at time of 9☐ Unknown	fdeath 5	Other (specify)					,
	requires thet the een signed by th hould be detache	by Pt	Part II. Other significant conditions of	ontributing to death bul not i	esulling in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco us	e contribute to th	e cause of death?
Records,	w require been sig should b	ed b	-					10	Yes 2K	No 3 □ Prob	ably 4 □Unknown
ecc		Completed						24a. Was		24b. Were auto	psy findings available appletion of cause of
R	sicien: The law certificate has t irector, page 2 s	Com							ormed? 2K No	death?	
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	11				ath (Check only o	one)		
of	Physi this c	5	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2		IL SU DOA				Other (Specify	()
UQ.	ding After fune	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	We	uryaı ork?]Yes 2∐No	28d. Describe	now injury	occurred	
Division	Attending or deeth.	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	home, farm, st			28f. Location (Street and	Number or Rura	l Route Number,
ă	s afte ni Dir	Certification:	4 Homicide	building, elc. (Spe	icity)			City or To	wn, State)		
	To the Hospital or Attending Physimiting 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral directors.	Medical	29a. Certifier 1 Certifying Phrone) 2 Medical Example	ysician: To the best of my kiner: On the basis of exam and manner stated.	inowledge, deal	h occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier			29c. Licen	se number		29d. Date	signed (Month,	Day, Year)
			me			F	126154		5	14/07	
			30. Name and address of person who o	The second of the second of							
	(لح	Dr. P. Daniel Mil 31. Date filed (Month, Day, Year)	ler, DO 69		res Road	l, Oakland	i, Maryl	and	21550	
	Sta Registr			2007 January 2007	Ar.	Coll 3					
DH	MH 17 Rev 1/2				A						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** RALPH BURNETT Jr. 16:00 PM May Marvin 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1**X** M 2□ F Director 217-40-2917 Jan. 5 1943 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10d. Inside City Limits r 28a-f show notified at Yes 2□No Funeral Director Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 209 N. Second Street 21550 United States ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by 3 Widowed 4 Divorced Vietnam White natural permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the M. dicalionee. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lawyer/Judge Law/Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph M. Burnett, Sr. Betty Owens ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chase Burnett, Son 17747 Davidson Drive, Sharpsburg, MD 21782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 5/12/07 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Sweitner Katherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronary Artery Disease Unknown /Medical Due to (or as a con eq ence of): Examiner Multi - embolic day Stroke Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Thrombocytopenia and burial-trar Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastatic Prostate Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hyperlibidemia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ne 24a. Was an page 2 autopsy performed? Hypertension
Was case referred to medical examiner? certificate Physiclan: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Dunehta 8 RES 000 2007 M.D. +IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

BIJAL

31. Date filed (Month, Day,

MEHTA,

2007

Year)

600

NORTH

32. Registrar's Signature

WOLFE ST.,

BALTIMORE

21287

MD

			1- For State of Maryland / Department / Department /	artment of Health and Martificate of Death	lental Hygier	
			Registrar 1. Decedent's Name (First, Middle, Last)	inicate of Death	Reg. N	No. Z U U J O A U A J
	Physici /Medic		Winifred Theresa Bacon		Month E	2007 5:00 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	<u>. To pometro e co</u>		8354 Newark Road	Newark		orcester
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M XX F 85 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	or det.		Usual Residence of Decedent		Oct. 4, 1	921 Maryland
	trylan show	_	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside Cify Limits
	he Ma 18a-f s otified	ecto	Maryland Worcester Newark			XXYes 2 □ No
	with t	ij	10e. Street and Number 8354 Newark Road	10f. Zip Code 21841		Citizen of What Country?
	death ms 23	Funeral Directo		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
ي	after or ite		1 Never Married 2 Married 1 Yes 2√ No		Rican, etc.)	Black, White, etc.
215-0036	hours ural", ul Exa	d by	3 Nidowed 4 Li Divorced Year or Dates:	1 ☐ Yes 2☐ No Specify:		Specify: White
7	in 72 t "nat ledica	olete	15. Decedent's Education 16a. Decedent's Education (Give (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ing 16b.	Kind of Business/Industry
212	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homem		Hom	emaking
	be filed within 72 hours after death with the Marylar tital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	en Surname)
Sla	should be and Mental s marked c umatic eve	인	Walter Joseph O'Malley	Winifred		
Maryland				ng Address (Street and Number or Rura		
	es 1 and 2 of Health of fitem 27 is r other tra		20a. Method of Disposition 20b. Place of Dispo			.1841 Location - City or Town, State
baltimore,	permit. Pages 'Department of H Important: If ite any Injury or of		XXDunai 2 Dolemation 3 Dhemoval non State	dral Cemetery 5/12		timore, MD
a	Departm Departm Importar any Injur			2. Name and Address of Facility		William St.
2	De E			e Burbage Funeral		in, MD 21811
	*		23a. Part 1. Enter the disease, of complications that caused the death. Do not ent shock, or heart failure. List only one cause of each line.		^	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Attenus Cuernum a.	CAMAJOVASCU	LAR DIS	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	1. 10.00		
	HEAD	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Fig. 7. Due to (or as a consequence of):	CLARON		
	cuted nd ransit	Examiner	that initiated events	A		
00,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
200	cate b	dical	d			
XOC	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			Ond Data of dalling
ă	The law requires that the death ate has been signed by the attennage 2 should be detached for u	iciar	1 Ves 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
5	at the by the tache	hys	9 ☐ Unknown			
'n	res that igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.		o use contribute to the cause of death?
cords,	requi	Completed			1 Tes	2 No 3 Probably 4 Unknown
ည ည	has by	mple			24a. Was an autopsy performed2	24b. Were autopsy findings available prior to completion of cause of
D.	in; Th		25. Was case referred to medical		1□ Yes 2☑N	
>	ysicia is cert directe	o Be	examiner? 1 Yes 2 No	26. Place of Death t 3 □ DOA Other: 4 □ Nursing Hor		6 ☐Other (Specify)
5	ng Phi Iter thi	L :u	27. Manne of Death 28a. Date of Injury 28b. Time of	— I ditaioning flor	28d. Describe how inj	
200	tendii eath. tor: A the fu	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
5	or At after d Direct in by	Certification:	4 Homicide determined building, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place.	and due to the cause((s) and manner as stated
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invane) and manner stated.	estigation, in my opinion, death occurr	ed at the time, date a	nd place, and due to the cause(s)
	Vithii vithii Comp	ğ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		4	Mener Su	D46257		5.9.2007
B	A 5		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) O OCEMPI CITY BE	VD. BERL	IN, MD 21811
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 9 2007 32. Bigistrar's Signature	D46257 LOOCEM CITY BY		

07-03460 Wilber Balmoris, Cr	4 10b		e or Print in B							07 1540
Wilber Balmoris Cr AMEN	1- For Steam	No peri	H,5/9/07,DPS,I	1500Certif	icate of De	ath		Re	2 U eg. No.	0/ 1040
Physician/ Medical Examine	Wilb		ruz					2. Date of Deat Month May 5, 200	Day Year 07	3. Time of Death 2327 hrs
به ۱۰۰۰ المهور ا	,	ame (if not institution iggs Road	i, give street and number	·)		ty, Town, o lelphi	r Location of Deat		4c. County of De Prince Geor	rge's
Funeral Director		urity Number 5-6158 Ince of Decedent	6. Sex 7. A	ge (In yrs. last		Under 1 Ye			th(MM/DD/YYYY) g. 3, 1986 Foi 17, 1986	Birthplace (State or reign Maryland Country Wash. D.C.
nd how any CE.	10a. State	10b. County			wn or Location					10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Mary 1 10e. Street at		ce George's	rd Avenue		Zip Code	20783	10	0g. Citizen of What C	country?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital St	atus	12. Was Deceder			edent of H ecify Cuba	ispanic Origin? (S in, Mexican, Puert	o Rican, etc.)	- 14. Race - An White, etc	
rs after ural", o	3 Widov		irced If Yes, Give Year or Dates: ify only highest grade co		1 X Yes		o specify: Sal		Specify: Wh	
36 nin 72 hour han "natu dical Exan	Elementar	y/Secondary (0-12)	College (1-4 or	<u> </u>		working life	e. DO NOT use re		Automob	
215-0036 be filed within 7 mtal Hygiene. riked other than ent, the Medical Be Comple		Name (First, Middle,	Last)					ne (First, Middle, M Dilma	Maiden Surname)	
MD 212 d 2 should b Ith and Ment n 27 is marl aumatic even	19a. Informar	B. Cruz nt's Name/Relationsh B. Cruz/		,	19b. Mailing Add 7001	23rd P	eet and Number or		Ayala nber, City or Town, Si e. Marvlan	
more, N Pages I and nent of Healti ant: If item	20a. Method 1 🗶 Burial	of Disposition 2 Cremation	3 Removal from S	20b. Plac tate crer	ce of Disposition (matory or other pl of Heav	Name of ce ace)	emetery, M	Date ay 9,	20c. Location - City	or Town, State
Baltin permit. P Departmet Importan injury or		of Fane a Service		ande	22. Name Fra	and Addres	Shof Facility CO11i		al Home I	
Physician /Medical Examiner	failure. L Immediate C	nter the disease, or clist only one cause ause (Final disease resulting in death)	complications that ause on each line. a. Multiple Injurie Due to (or as a cons	s						Approximate Interval Between Onset and Death
50		list conditions, g to immediate	b							
Led Insit	cause. Enter	Underlying Cause njury that initiated ing in death) Last	Due to (or as a cons	sequence of):		<u> </u>	<u> </u>			
be executed sician and urial - transit edical Ex	UNPE	NDED	a. X AMENDED #8,9,18,p	erInf, G	8675/30/	07 TT				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical E.	past 12 n	edent pregnant in the nonths?	23c. If yes, outco		cy 2 Fetal de	ath 3	Ectopic pregr	nancy	23d. Date of deli	very Day Year
ires that the de signed by the detached five		significant conditi	ons contributing to dea	th but not resu	lting in the underl	ying cause	given in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, all or Attending Physician: The law requirer is after death. al Director: After this certificate has been sighed in by the funeral director, page 2 should be ertification: To Be Completed								24a. Was autop perfor 1 ✓ Yes	rmed? prior	
ital Reisien: The scriffcate rector, page	25. Was case examiner		Hospital:	ient 2 EF	NOutpatient 3	26.Plac	Other Nurs		Residence 6 V O	thar Scone
ion of Virtending Physiceath. On: After this the funeral dirteration: To	1 ✓ Ye 27. Manner o 1 Natur	f Death	28a. Date of In (Month, Day May 5, 2007	jury 28	b. Time of Injury 305 hrs	28c. Inj	ury at Work? Yes 2 ✓ No	28d. Describe I	how injury occurred fixed object colli	
Division or spiral or Attending nours after death. neral Director: After filled in by the fune Certification:	2 Accid 3 Suicid 4 Homi	de 6 Could	not be nined (Specify) Lo		e, farm, street, fac	tory, office	building, etc.	or Town, S		Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier (Check only	1 Certifying Ph	ysician: To the best of r niner:On the basis of ex- and manner stated	ny knowledge, amination and/			•			
Me 2	29b. Signatur	e and title of certifier		-			.M.E.		29d. Date signed (Month, Day,Year)
,	30. Name and Ling Li,	·	who completed cause of	,	a) enn Street, B	altimore,	, MD 21201			
State Registra		(MAYay, Year	2007 32. segistr	ar's Signature	Book	9				

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of Fertificate of		Mental Hy	giene	7 16406
n dir	Dhi-		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	aath	3. Time of Death
A.,	Physic /Medi		Louis Wolcott Cam	ıp				May 5,	2007	11:53pm ^M
	Exami		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of De		4c. County of	
-		, o	401 Russell Avenu			Gaither			Monte	omery
	Funeral	,	5. Social Security Number 6. S	ex 7.Ag ⊠M 2□F	e (In yrs. last birthda)	(y) If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	ay, Year)	Birthplace (State or Foreign Country)
30	Director		578-14-0282 Usual Residence of Decedent		93 Yrs.			Oct. 26	, 1913 M	lississippi
	yland		10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	Mar.	ctor	Maryland Montgome	ery	Gaithers	sburg				1 🛣 Yes 2 🗌 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	ath w	rai	401 Russell Avenu	e #513		20877			United S	tates
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		. Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pue	Specify Yes or No	14. Race	- American Indian, , White, etc.
36	ilied within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28a-1 ehow ent, the Medical Examinat must be multied at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 ☒ No	Specify:		Specify:	
Š	2 hou	ed	15. Decedent's Ed	lucation		edent's Usual Occup.	ation		16b. Kind of Bus	White
215	hin 72	plet	(Specify only highest gra Elementary/Secondary (0-12)	de completed)	(Giv	e kind of work done of DO NOT use retired	during most of w	rorking	160. Kind of Bus	iness/industry
2	giene giene	Completed	Clombridary (0-12)	College (1-4or 5		President			Life Ins	urance Company
D	9 7 5	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,		
Maryland 21215-0036	Ment Ment arked arked	2	Royal Worth Camp				Mary Ka	therine	Maier	
Ja	es 1 and 2 should b of Health and Ments fitam 27 is marked r other traumatic e		19a. Informant's Name/Relationship (7		19b. Mai	ing Address (Street a	and Number or I	Rural Route Number	er, City or Town, S	itate, Zip Code)
	1 and dealth am 27 ther t		Gary Camp	(Son)	271 9	Stoney Cre	ek East		ford, VA	22958
و	Pages nent of thint: if its int: if its		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		cemetery, cre	osition (Name of ematory or other plac	е)	Date	20c. Location - C	city or Town, State
altimore,	urtmer urtant urtant		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen.			itan Crema				ia, Virginia
ga	permit. Pages Department of important: if it any injury or o		21. Signature of Editeral Service Licen		1	2. Name and Addres O East Dec aithersbui	ss of Facility [DeVol Fun Drive	eral Hom	e
nd (disk	3.	i i	23a. Pant. Enter the disease, or comp	plications that caused	the death. Do not en	aithersbui	rg, MD 2	20877		A
	Physician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each in	10.		g, such as cardi	ac or respiratory at	1851,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		ve Cardion a consequence of):	nyopathy				Years
	Examiner			_	Artery D	icasca				Vocate
Щ,	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):	Lacase				Years
	ecuter ind transi	Examine	that initiated events	c						
Ď,	be executed icisn and burial-transit		resulting in death) Last	Due to (or as a	a consequence of):					
9/20	cate chys the	dicai		d						
×	certifi ding se as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					
X D D	death e atter	clan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal déath 3 (□Ectopic pregnancy □ Other (specify)			23d. Date Montl	,
j.	the d	Jys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	inia di dealii 50					,
τ. Τ	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions co	ntnbuting to death bu	it not resulting in the u	inderlying cause give	n in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ecords	an sig	ed b						1 🗆 Y	es 2 🗆 No 3	☐ Probably 4 🏗 Unknown
ວ	law re as bee	Completed						24a. Was :	an 24b We	ore autopsy findings available
	sician: The law certificate has b irector, page 2 s	E						autop perfor	sy prion	or to completion of cause of ath?
	ysician: The is certificate he director, page	Bec	25. Was case referred to medical examiner?	8			26. Place of De	1 ☐ Yes ath Check only or		Yes 2 No
5	<u>></u> .≝ 0	၉၂	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3 DOA Othe		Home 5⊠Resid		(Specify)
	ing P	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injury Work			ow injury occurred	
	Attending ir death. ector: Aftsr by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	2		M 1 1 Y	'es 2 □ No			
<u> </u>	or Al after of Direction by	Certification:	4 Homicide determined	28e. Płace of Inju building, etc	ry - At home, farm, sti . (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
1	purs a eral I		29a. Certifier 1/X Certifying Phy	alalan Turk						
:	24 hos 24 hos Fun etely	Medical	(Check only one) 2 Medical Exami	ner: On the basis of and manner stat	f my knowledge, deat examination and/or in	vestigation, in my opi	inion, death occ	e, and due to the e urred at the time, o	ause(s) and mam. late and place, and	er as stated. d due to the cause(s)
	to the Hospital or Attending Ph within Z4 hours affer death. To the Funeral Director Affer th completely filled in by the funeral	Me	29b. Signature and tipe of certifier			29c. License			9d. Date signed (i	
				1) ohn	100	חחו	1248			
	10	1	30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type				May 7, 2	2007
			Steven Dolinsky, M				rsburg,	MD 20877	7	
	Stat	е	31. Date filed (Month, Day, Year) MAY 08 20	22 4 2:2	da Cionatura					
	Registra	ir	meri U O ZU	U Dieku	J. K. A.	BUZ!				

	AT.		1- State of Maryland / Department / Department / Dep	artment of Health and Natificate of Death	Mental Hygid	ene 3. No2 () () ()	16407
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Mary Jo Cameron		2. Date of Death Month May	Day Yea 6 20	
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1147	4c. County of De	
			College View Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Frederick If Under 1 Year If Under 24 Hrs.	8. Date of Birth		erick
	Funeral Director		215-36-5667 1□M 2⊠F 68 Yrs.	Months Days Hours Min.	(Month, Day,) March 10	rear) (irthplace (State or Foreign Country) ashington, D(
	land bw it		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	h the Marylan r 28a-f show s notifled at	tor	Maryland Frederick Fred	erick			1⊠Yes 2 No
	vith the	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What (Country?
	ath w s 23a nust b	lal	700 Toll House Avenue	21701		United	
336	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notifled at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☎ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
21215-0036	ges 1 and 2 should be filed within 72 hou to f Health and Mental Hygiene. If item 27 Is marked other than "nature or other traumatic event, the Medical E	Completed	(Specify only highest grade completed) (Give life. I	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	Sb. Kind of Busines	s/Industry
72	e filed was Hygier other the	ខ	17. Father's Name (First, Middle, Last)	Anaesthesiologis		Medica	a <u>1</u>
Maryland	id be f ental I ked ol c eve	o Be	John Beaton		e (First, Middle, Ma	uden Surname)	
aryl	2 should be and Mental Is marked raumatic ev	으		ng Address (Street and Number or Run	na Lane al Route Number, (City or Town, State,	Zip Code)
	s 1 and 2 of Health item 27 is other tra			Raccoon Court Wa	ldorf, Ma	ryland 20	0603
lore	iges 1 It of H If iter or oth		I Donal 2 kg Clemation 3 Memoral from State	sition (Name of natory or other place) Mav	Date 20	c. Location - City of	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		4□Donation 5□Other(Specify) Stauffer	Crematory : 200)7 F	rederick,	Maryland
Ba	Depa Impo		16	Name and Address of Facility Star 521 Opossumtown Pi	ıffer Fun ke Frede	eral Home erick, Ma	es, P.A. ryland 21702
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease of complications that caused the death. Do not ent shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	Heart fail	or respiratory arrest	t,	Approximate Interval Between Onset and Death
68760,	ician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
P.O. Box	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
	ss that gned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
ord	require sen sig	ted !	Acule on chronic per	al failung	1 ☐ Yes	2 No 3 □ F	Probably 4 ☐ Unknown
al Records,	r: The law icate has b r, page 2 sl	Completed			24a. Was an autopsy performer 1 Yes 2 ■	d? prior to death?	utopsy findings available completion of cause of s 2 □ No
Vital	Physician: this certificatal director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death			
J Or	ding Phys I. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Daursing Hor	ne 5∐ Residenc 28d. Describe how	e 6 Other (Speninjury occurred	ecify)
Division		Certification:	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation 3 □ Suicide 4 □ Homicide determined (Month, Day Year) Injury 28e. Place of injury - At home, farm, streething building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	et and Number or F State)	iural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Certifying Physician: To the best of my knowledge, death one of examination and/or invariant and manner stated.	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	Tot Tot Com	Ž	29b. Signature and title of certifier MY	29c. License number	29d.	Date signed (Mon	th, Day, Year)
	Sta Registr	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type, If the standard of the standard	is Johnson Dr	Fred	levick	MD 21702
DU	MH 17 Pov 1/0		7 2 /9				

			1 - For State Registrar	ate of Marylar		artment of H			iene	07	16408
	Discovini.		Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Elva June Cool					May		007	6:41PM M
	Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Dea	th	4c. County	of Death	
			Washington County Ho				gerstow		Washi	ngtor	n County
п	Funeral		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year)	Coun	
	Director		Usual Residence of Decedent	79				June 26	1927	Peni	nsylvania
	yland Now		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	Mar	tor	Maryland Washingto	on	W	illiamspo	rt				1 ☐ Yes 2X No
	th the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of \	What Coun	itry?
	th will		16505 Virginia Ave	enue		2	1795		U.S	. Δ	
	eep see	Funerai		as Decedent Ever in U	.S. 13. \			Specify Yes or No- rto Rican, etc.)	14. Rac	e - Americ	an Indian,
36	or it		1 Never Married 2 Married 1	JYes 2 [®] No Yes, Give		I□Yes X No	Specify:	,		whi	
Ö	within 72 hours after deeth with the Maryland ene. then "naturel", or items 23s or 28s-f show the Mudical Experiment hust be multiled at	d by		ear or Dates:	1 40 - D						
7	n 72	Completed	15. Decedent's Education (Specify only highest grade com		16a. Deced	lent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wo	orking	16b. Kind of Bu	usiness/Inc	dustry
7	withi ene. then	E	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)		sembler	,		Glass	Manuf	acture
0	filed Hygie Dther	a l	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M			
<u>a</u>	Mental I	To B	Warren Scott Kenne	edy			Mary	Kathryn M	Maun Ke	nnedv	7
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked other then 'naturel', or items 23s or 28s-1 show atmatic event, the Medical Exemities must be notified at	-	19a. Informant's Name/Relationship (Type, Pi	rint)	19b. Mailin	g Address (Street a		ural Route Number,			
Ž	elth a elth a 27 is		Randy J. Cool (son	1)	1470	7 Pennsy	lvania A	ve. Hager	esteum	Maryl	and 21742
e,	of He of He roth		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place		Date	20c. Location -	City or To	wn, State
Ĕ	Page nent of int: if		1 Burial 2 □ Cremation 3 □ Remov □ Donation 5 □ Other (Specify)					9 2007 0	Greenca	stle	Pennsylvani
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: if tem 27 is marked eny injury or other treumatic events.		21. Si nature of Funeral Service Licensee	-							-
<u> </u>	89 5 5 9		Dunck At	ur.	13	331 Easte	rn Blvd.	N. Hager	stown	Maryl	eral Home and 21742
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the deat se on each line.	h. Do not ente	er the mode of dying	g, such as cardia	c or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Bulater	cal	Pheur	nonia			_ 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		1.1				
	LXammici	_	Sequentially list conditions, b.	D							
_	bed sit	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury	Due to (or as a conseq	dence or):					-	
	be executed sician and burial-transit	xar	that initiated events c.	Due to (or as a conseq	uence of):					-	
8760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dicai									
687	p physicate as the	edic	0.								
ŏ	eath certific attending p	2		yes, outcome of pregna					23d. Dat	e of delive	ry
m.	death e atte	Physician/Me	1 Yes 2 No	Live birth 2 Feta Pregnant at time of d		Ectopic pregnancy Other (specify)			Mo	nth	Day Year
o.	by th	hys	9 □Unknown	Unknown							
'n	res thet the de igned by the be detached (Part If. Other significant conditions contribution	ng to death but not-res	ulting in the ur	derlying cause give	on in Part I.	23e. Did tob	acco use contr	ibute to the	e cause of death?
p	w require been significant	ted	Coronary Hite	ry Dise	ase_			1 ☐ Ye	s 2 10 No	3 Proba	ably 4 □Unknown
ဝိ		pie	Cervical Cance	0				24a. Was ar		Vere autop	osy findings available
Vital Record		Completed by	Diabetes Me	Ilitus :	TYPE	71		perform	ned?/	leath?	2□ No
/ita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?		17			ath Check only one)		
	Physi this al din	은	1 Yes 2010 Hospita	1 Impatient 2	ER/Outpatien		4 🗆 Nursing r	dome 5 Reside)
ב	E E	<u>o</u>	The state of the s	n. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurr	ed	
S	or Attending ter death. irector: After by the fune	lcat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At he	ama farm etre		fes 2 □No	28f. Location (Str	mat and Alumb	25 25 Quan (Courte Mumber
Division of	2 # # 5	Certification:	4 Homicide determined 200	building, etc. (Specif	y)	et, ractory, office		City or Town	. State)	er or Hurai	Houle Number,
	port surger surg		29a. Certifier Certifying Physician	: To the best of my kno	wledge, death	occurred at the tim	e, date and place	e, and due to the ca	use(s) and ma	nner as etc	ated.
	P Fu	Medical	(Check only 2 Medical Examiner: 0	n the basis of examina nd manner stated.	tion and/or inv	estigation, in my op	inion, death occi	urred at the time, da	ite and place, a	and due to	the cause(s)
	To the Hos within 24 h To the Fun completely	ž	29b. Signature and title of certifier HOSPI	talist		29c. License	number	29	d. Date signed	(Month, E	Day, Year)
			Fuced of	Derucaso		KOO	6117	1	nay	4.2	2007
, .	_	1	30. Name and address of person who complete	ed cause of death (Item	1 23a) (Type, I			- Danie	15 Di	\circ	
クト	1-8		251 E MATIETA	im St >	4400	stown	NOD !	21740			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 0 2007	32. Registrar's Signa	iture /						
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		_1	For State Registrar	State of	Marylan				ealth a Death	and Me		gienę Reg. Nd.	41111	7	16	409
	sicia:	n	1. Decedent's Name (First, Middle, L EVA VIRGI	NIA CH	HURCH	HEY					Date of Dea Month	ith Day	O Ye	∍ar 7	3. Tin	ne of Death
	imine		a. Facility Name (If not institution, g Western Maryland Hos	ive street and numi	ber)	1	'	, Town, or rstown	Location o				County of I			
Fune Direc			220-26-2429	Sex 7 1 □ M 2 □ X F	. Age (In yrs.		If Unde Months	Days	If Under 2 Hours	Min	B. Date of Birth (Month, Day ay 19,	193	9. 1 W	Birthpl Count est	ace (St	ate or Foreign ~ginia
the Maryland		ctor	Usual Residence of Decedent 10a. State 10b. County Mary land Wash 10e. Street and Number	ington	10c. Cit	y, Town or Lo	Shar	psbur	g			10g. Citi:	zen of Wha		1 📮	de City Limits Yes 2 X No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 to marked other then "natural", or items 23a or 28a-1 show		by runeral	17357 Shepherds† 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced	es? No			dent of Hi ecify Cuba	21782 spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	ify Yes or No- can, etc.)		14. Race Black, \	White, 6		
d 21215-0 filed within 72 ho Hygiene. ther then "natur		Completed	15. Decedent's (Specify only highest g		for 5+)	life.	kind of w DO NOT	ork done d ise retired	lurina most	t of working		16b. Kir	nd of Busin	tau.	,	
Maryland 21215-0036 ad 2 should be filed within 72 hours at th and Mental Hygiene. 77 te marked other then "naturet", or	Supplemental Suppl	10 Be	17. Father's Name (First, Middle, La: James Frankli	n Zombro)				18. Mothe	r's Name (zabet	First, Middle,	e Ca	Sumame)			
ore, Mar es 1 and 2 sho of Health and of Hem 27 le m			19a. Informant's Name/Relationship Harold E. Church 20a. Method of Disposition	ey - Hust	20b. F		She	phero	dstowr		Route Numbe e Shart te	osbu		ary	land	
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Division of Vital or Attending Physician: after death. Director: Attent this certifice	completely timed in by time tuneral director, page	Certification:	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	on be 28e. Place of	, Day Year) of Injury - At ho g, etc. (Specif	Injury ome, farm, str	М		t? Yes 2∐t	No	If. Location (S City or Tow	treet and	d Number (or Rurai	Route	Number,
Hospita 4 hours Funarel	pietety titlet	edical	29a. Certifier Check only one) Certifying R	Physician: To the baseminer: On the basemann	is of examina	wledge, death tion and/or in	vestigatio	n, in my or	oinion, deal	d place, an	I at the time, o	date and	place, and	I due to	the cal	
To the within 2 To the 1	COU		29b. Signature and title of certifier	72-	•				996				e signed (A			
SH-S	5			< Mb.			-		_	vania <i>l</i> D 21742						
Red	Stat	-	31. Date filed (Month, Day, Year)	2007 32. Re	istrar's Signa	iture	last.	1	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** рм DeRita 5 May 2007 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11110 Orleans Way Kensington Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1**x** M 2 □ F Director 213-14-8971 85 May 19, 1921 Italv Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f sh must be notified 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11110 Orleans Way 20895 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 1 □ Yes 2 □
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 1942-45 Specify: Specify: White 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stonemason Building Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pasqualino Giusippe Francesco DeRita ပ Maria Filomena Zarrelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Louise Ann DeRita/ Wife 11110 Orleans Way, Kensington, Maryland 20895 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of
Important: If It
any injury or o 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only one is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ase on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Mesothelioma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical use as ding IF FEMALE yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth atter 3 Ectopic pregnancy in the past 12 months? Month Dav Year ned by the ai 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has birector, page 2 s 2 3 No Division or Vital 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury nours after death.

neral Director: A

filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hor To the Fune and manner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64615 May 7, 2007 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D. 1355 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 08 2007 Registrar

07-0341	2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

arian K. Dawsoi	1	- For State Certifica	te of Death	nygiene Reg. 1	200	7 1641
Physicia: ledical Examin	n/	Decedent's Name (First, Middle,Last)		Date of Death Month Date		3. Time of Death 1055 hrs
iedicai Examin		Harlan Ray Dawson, Sr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deal	May 4, 2007	4c. County of Death	10331113
		Prince George's Hospital	Cheverly		Prince George	s
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 214-42-3045 6.5	day) If Under 1 Year If Under 24H Months Days Hours Mi	n	MM/DD/YYYY) 9. Birth Foreign), 1941 Cou	Maryland
* any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	Director	Maryland Prince George's 10e. Street and Number	Hyattsville 10f. Zip Code	10g.	Citizen of What Coun	1 Yes 2 X No
the Na or 3		5603 29th Avenue	20782		USA	
death with the Maryland or items 23a or 28a-f sho	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		14. Race - Americ White, etc.	an Indian, Black,
irs after ural",	호-	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. D	1 Yes 2 X No specify:	f work done 16	Specifwhite Sb. Kind of Business/Ir	ndustry
136 hin 72 hou e. than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use re essional Driver		Truck	
	Be Con	17. Father's Name (First, Middle, Last) Rolland Wallace Dawson		ne (First, Middle, Mai arl Doris	-	
MD 2121 nd 2 should be fi lith and Mental I nn 27 is marked aumatic event,			Mailing Address (Street and Number of 603 29th Avenue, H			
Baltimore, I bermit. Pages I and Department of Heal Important: If item		1 V Rurial 2 Cremation 3 Removal from State cremato	f Disposition (Name of cemetery, by or other place) wn Memorial Park	ay 10,	Oc. Location - City or	
Saltir emit. F epartme nportar	İ	21. Signature of Juneral Service Licensee	22. Name and Address of Facility Francis J. Collin		Rockville. Home Inc.	Maryland
	-	23a. Part I. Enter the disease, or complications that caused the death. Do no	500 University Bl	vd. W. Si	ver Spring	MD 20901 Approximate Interval
Physician /Medical *xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	content and mode of aging, addition as cardinate	, or roop natory arrost		Between Onset and Death
		Sequentially list conditions, b				
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scuted and transit	al Exar	events resulting in death) Last Due to (or as a consequence of): d.				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5		nancy	23d. Date of delivery Month D	lay Year
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Division of Vital Records, na or Attending Physician: The law requir is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a sh	Completed			24a. Was an autopsy perform	prior to o ed? death?	topsy findings available ompletion of cause of
ital Recionant The scertificate rector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Checutopatient 3 DOA Other,			
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Divisior Hospital or Attence 24 hours after death Funeral Director: stely filled in by the	Certification:		rm, street, factory, office building, etc.	28f. Location (Stroor Town, State		ral Route Number, City
To the Hosp within 24 ho To the Fune completely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated,	oth occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause(d at the time, date an	s) and manner as state d place, and due to th	ed. e cause(s)
F 1 2 3	M	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed <i>(Moi</i>	nth, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	3.3.11112.		-, -,	
			111 Penn Street, Baltimore, M	D 21201		
St Regist	ate	31. Date filed (Worth Day Year) 2007 32 Registrar's Signature	Scarte)			

			1 - For State Registrar	State of M	larylar		artment			nd Mental	Hygier	200		16412)
3	9 4 7		Decedent's Name (First, Middle, La	st)						2. Date of	of Death			3. Time of Death	•
4	Physici /Media		William John Do	err						May	3, 20	07	Year	10:05 A	А
1	Examir		4a. Facility Name (If not institution, giv			_			Location of	Death	-	4c. County of	f Death		
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	or 28	Director	10e. Street and Number				10f. Zip	Code			10g. (Citizen of Wh	nat Countr	y?	_
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920	be filed within 72 hours after death with the Maryland stal Hygiene. do other than "natural", or items 23e or 28e-f show event, the Medical Exeminal must be notified at	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates:	?		Was Decedor f Yes, spec	ify Cubar	spanic Origin, Mexican, Specity:	n? (Specify Yes o Puerto Rican, etc	or No- .)	14. Race Black, Specify:	, White, et	c.	
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	is 1 and 2 should of Health and Mer flem 27 is marke other traumatic		19a. Informant's Name/Relationship (Philip Doerr/son	Type, Print)		19b. Mailir 5930	ng Address Sereni	(Street a Lty]	nd Number Lane D	or Rural Route No Derwood,	MD 20	or Town, Si 0855	tate, Zip C	Code)	
Baltimore,	permit. Pages 1 Depertment of He Importent: If ite- any Injury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			Place of Dispo cemetery, crer esapeal	natory or oti	her place	· 1	Date 05/05/07		Location · C ltsvil			
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90	12		30. Name and address of person who	completed cause of cause of cause o		23a) (Type,								ns mo 209	e/,
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			Decedent's Name (First, Middle, La	ast)								of Death			3. Time	of Death
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	/Medic Examin		4a. Facility Name (If not institution, gir				4b. City	, Town, or	Location of	of Death			4c. County	of Death	3.45	•
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	다 다 0.22)ire	10e. Street and Number				10f. Z	ip Code				10g.	Citizen of \	What Cou	ntry?	
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Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship				-						y or Town,		Code)	
2	and ealth m 27		Barbara I. Dunba	r/ Wife					th St				[aryla		21550	
ore	of H of H if Ite		20a. Method of Disposition 1 1 Burial 2 ☐ Cremation 3 (Removal from Stat		Place of Dispo cemetery, crei	sition (Na matory or	ime of other plac	e)	D	ate	20c	. Location -	City or T	own, State	
altimore,	Pag ment ant: ury		4 ☐ Donation 5 ☐ Other (Spec			rrett (Co. M	lem. (Gds.	5/7	/07	0	aklan	d, Ma	aryla:	nd
ā	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show with injury or other traumatic event, If a Mudical Expiration must be notified at ance.		21. Signature of Funeral Service Lice	nge-		22	2. Name a	ind Addres	s of Facilit	ty		32 S.	Seco	nd St	t.	
Ф	20 E 2 9		John My	lland		St	ewar	t Fu	neral	Hom	e 0	aklar	id, MI	21	550	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	ed the deat	th. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respirat	ory arrest,			Approxim Interval B	ate etween
	Physician		Immediate Cause (Final disease or condition	1 10	10.00	1	and i	_							Onset an	d Death
	/Medical		resulting in death)	Due to (or a	s a consec	quence of):	ce1								900	¢ A
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ó	an ar rial-t	Ä	resulting in death) Last	Due to (or a	s a conseq	quence of):										
8760,	icate be executed physician and s the burial-transit	dicai		d												
9		led														
Вох	ih cei endir r use	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Tectonic r	oregnancy					23d. Da	te of deliv	ery	
<u>.</u>	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant			Other (s						Mo	nth	Day	Year
Ö	that the death certifi ed by the attending I detached for use as	hys	9 🗆 Unknown	9□Unknown												
Division of Vital Records, P.O.	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.	•	23e.	Did tobaco	co use cont	ribute lo t	he cause o	f death?
ë	w require been sig should b	ba										1 k Yes	2 🗆 No	3 Prol	bably 4 []Unknown
ပ္ပ	s been shoul	Completed									24a.	Was an	24b. '	Were auto	opsy finding	s available
8	he tay	E										autopsy performed	?]	death?		s available cause of
ē	tician: Th certificete rector, pag		25. Was case referred to medical						22 51		10		No	1 🗆 Yes	2 □ No	
>	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tions 2	ER/Outpatier	nt 3□ D	Othe	26. Place				a F30#	10		
o	Phys or this oral di	. To	27. Manner of Death	28a. Date of In (Month, D		28b. Time o		28c. Injury Work	4 🗆 140				6 □Oth		(y)	
o	ding th. : After funer	盲	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		lay Year)	Injury	м		k? Yes 2 ∐i				, , , , , , ,			
<u>IS</u>	Attending ir death. ector: Affer by the fune	fica	3 ☐ Suicide 6 ☐ Could not I	De Olean of I	niury - At h	ome, farm, str					28f. Loca	ion (Street	and Numb	er or Run	al Route Ni	ımber
É	after Dire	Certification;	4 ☐ Homicide determined	building,	etc. (Specil	(y)		7, 300			City	or Town, Si	tate)	2. 7 1071		
_	Hospital 24 hours Funeral etely filled		29a Cartifier 1K Certifying P	hysician: To the bee	t of my kno	twiet echalwo	h secure	f at the te	to data as	distance of	arat daa t	otha caus	deliante	Laborar -	tatori	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exa	miner: On the basis and manner:	of examina	ation and/or in	vestigatio	n, in my of	pinion, dea	th occurr	ed at the	time, date	and place,	and due t	o the cause	9(s)
	within To the Comple	Me	29b. Signature and title of certifier				29	c. License	number			29d.	Date signe	d (Month,	Day, Year,)
	r > F 0		1 And	,0 1					H26	5154			_	/07		
•			30. Name and address of person who	completed cause of	death /lter	n 23a) /T	Print1						- 773	10		
	VA	15	Dr. P. Daniel Mi			Wolf A		Dr	()ak1	and	Mar	vland	215	50		
	Sta	to	31. Date filed (Month, Day, Year)	The second secon	trar's Signa			D1.,	JURI	- with 9	naı	<i>,</i> - and	. 213			
	Registr		MAY - 8	2007	0	Pr A	A. B	2								

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Registrar		of Marylar		artmen rtificat				lental Hyg	ienę ()	07	16414
П	Physici	an	Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medi		Rena Mae Durst								May 12	, 2007	7	2:50 P M
	Examir	er	4a. Facility Name (If not institution	n, give street and no	im <i>ber</i>)		4b. City,	Town, or	Location o	of Death		4c. Cour	nty of Death	
			Dennett Road Ma		ng Home	:	Oakl					Garr	ett	
п	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)
	Director		218–16–4111			83 Yrs.					(Month, Day Aug. 28	1923		nsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c, C	ity, Town or Lo	cation							10d. Inside City Limits
	Marylan f show	5	MD Garr	ott.		.endsvi							ĺ	1 □Yes 2X No
	vith the Mar or 28e-f st be notified	Director	10e. Street and Number		FLI	.enasvi	10f. Zip	Codo				0g. Citizen o	of Market Con	
	death with the Maryland ms 23s or 28e-f show I must be notified at	ā		Dood				1531			'	USA	or withat Cou	muy?
	eath w	Funerai	148 Frank Sisle		edent Ever in U	I S 13	1		spanio Orie	nin? /Sn/	oitu Vas as Na		ace - Amer	icae Indiae
40	ter dea	ä	1 ☐ Never Married 2 ☐ Marr	Armed F	orces? 2 🔀 No	7.3.	If Yes, spec	offy Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		lack, White	
38	hours after tural, or ite al Evamine	by	3 ₩ Widowed 4 Divorced	If Yes, G Year or I	ive		1 ☐ Yes	2 ⊠ No	Specify:			Spec	ify: Wh	ite
ŏ	72 hours "natural", adical Exe	Completed	15. Decedent			16a. Dece	dent's Usua	al Occupa	ition			16b. Kind of		
215	within 7 ene. then "n	pie	(Specify only highes Elementary/Secondary (0-12)	1	1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired,	luring most)	t of worki	ng			,
21	d with	O.	10	Conege	1-401 34)	Facto	ry Wo	rker				Radio	Compo	nents
Maryland 21215-0036	d 2 should be filed within ; h and Mental Hygiene. 7 is marked other then "r treumatic event, the Men	Bec	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle, I			
<u>a</u>	Alenta Alenta rked tice	To	Frank Sisler						Verna	Ril	ev			
ar	s ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address				I Route Number	City or Tow	m, State, Zi	p Code)
	s 1 end 2 should be filed within 72 hours after death w I Heelth and Mental Hyglene. Item 27 is marked other then "natural", or items 23a other treumatic event, I're Medical Examiner must.		Janice K. Bower	/Sister		148 F	rank	Sisl	er Ro	d., F	riendsv	ille,	MD 2	21531
Baltimore,	permit. Pages 1 end 2 Department of Heelth a Importent: If item 27 is any injury or other tre ange.		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of ther place	e)	D	ate	20c. Location	n - City or T	own, State
Ĕ	Page nent iny or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		State	ele Ce			'	14,	2007 F	riends	ville	, MD
alti	mit. Partn Porte V inju		21. Signature of Funeral Sanrice	Licensee			2. Name an				wman Fu			
Ö	Department of the partment of		Degue 1 16	uman		P	.O. B	ox 2	75, 6	rant	sville,	MD 2	21536	
			23a. Part1. Enter the disease, or shock, or heert failure. List	complications that	caused the dea	th. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory arre	est,		Approximate
	Physician		Immediate Cause (Final			1-1	C 21	1	. 1		1			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		(or as a consec		ava	i Va.	sculu	1	disease	2	-	years
	Examiner				,	,								
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	quence of):								
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ó	en ar en ar rial-t	EX	resulting in death) Last		(or as a consec	uence of):						-		
8760,	The law requires that the death certificate be executed tie has been signed by the sttending physicien and page 2 should be detached for use as the burial-transit	dical		d										
9	tifica ng ph as th	ed led		T					,					
Вох	that the death certific ed by the sttending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pro	0000001				23d. D	ate of deliv	ery
	the att	100	in the past 12 months? 1 □ Yes 2 No	4□Pregi	nant at time of o		Other (sp					N	Month	Day Year
P.0	by the	Ę,	9 □Unknown	9□Unkn										
	signed by det	by F	Part II. Other significant conditio	ns contributing to d	eath but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	ecco use co	ntribute to t	he cause of death?
p	w require been sign should t	ed	ischemic 9	augrene	of	right	100	Y			1 □ Ye	s 2 No	3 🗆 Prol	pably 4 □Unknown
of Vital Records,	awre is be	Completed	hypertensio	n		*					24a. Wasai		. Were auto	ppsy findings available
ď	The I	E	Palvar	the ma	Vero	1			-		autops	ned?	death?	mpletion of cause of
ta	an: tifica tor, p	a	25. Was case referred to medical	THE DATE	VEYO				26 Place	of Death	(Check only one	2 DA No	1 Yes	2 No
<u>></u>	Physician; this certificatal director,	ToB	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DO	A Othe			ne 5 Reside		ther /Specie	641
ō	g Ph er th eral		27. Manner of Death	28a. Date	of Injury	28b. Time of		Bc. Injury Work			28d. Describe ho			<i>y</i> /
jo	ndin ath. r: Aft	atio	1 Anatural 5 Pending 2 Accident investig		th, Day Year)	Injury	М		es 2 □ N	No				
Division	Atte	E C	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At h	ome, farm, str	eet, factory	, office		2	28f. Location (Str	eet and Num	nber or Rura	al Route Number,
Ö	s effe	Certification:	4 Hottlicide	build	ing, etc. (Specii	y)					City or Town	, State)		
	hour hour mere y fille	- 1	29a. Certifier 1 Certifying	g Physicien: To the	best of my kno	wiedge, death	occurred a	at the time	e, date and	d place, a	and due to the ca	use(s) and n	nanner as s	tated.
	To the Hospitel or Attending Physician: The law within 24 bours elled death. To the Funerel Director Atte this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical 6 one)	examiner: On the b	asis of examina ner stated.	ition and/or inv	estigation,	ın my opi	inion, deatl	h occurre	ed at the time, da	ite and place	, and due to	the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	/				License				d. Date sign		
	1		4/100	W The	man	_Mr		000	125	7	59	May 1	12, 2	007
	,	-	30. Name and address of person v	who completed caus	se of death (Iter	n 23a) (Type.								
			walter k.	Nou ma	,		UXZ	-4	7. A	ecil	clory h	1021	520	
	Sta Registr		31. Date filed (Month, Day, Year)	5 2007 32. 5	egistrar's Signa	ature	Sugar Me	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Physician 2007 7:45FLOYD MAY 10 WILLIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON 110 SAINT PAUL STREET BOONSBORO Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**⊠** M 2□ F Yrs. Director 93 26. 1913 MARYLAND 213-12-7396 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show treumatic event, the Madical Examiner rust be notified at 1X Yes 2 No Directo MARYLAND WASHINGTON **BOONSBORO** 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21713 U.S.A. or Items 23a 110 SAINT PAUL STREET Completed by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or Iter ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 MACHINIST PARTS MANUFACTURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD B. DOYLE DAISY E. GABE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21149 KEADLE ROAD, BOONSBORO, MARYLAND HARRY L. DOYLE/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 1 4 □ Donation 5 Other (Spe 5/14/2007 BOONSBORO CEMETERY BOONSBORO, MARYLAND 22. Name and Address of Facility
BAST FUNERAL HOME 21. Sign ure of 7606 Old National Pike Paul M. Dean Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death Part I. Enter the disease, to complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 20 menths **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE be detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 No 3 Probably 4 Unknown Yes Completed 24a. Was an autopsy performed?
1 ☐ Yes No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled in t within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifiers

OH-12

State Registrar , MD 0 113 C , 32. Prigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4. Spende

DHMH 17 Rev 1/2001

State Registrar Mem. Hosp Med Bldg Cumberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Robustiano Barrera M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Bella 08:50 PM Mae 2007 may 13 /Medical 4a. Facility Name (If not institution, give street and number) Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Frostburg Village Nursing Care Allegany Frostburg If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (in yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 212-74-7692 1□M 2**X**F Days Hours 104 October 28 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or Iteme 23a or 28e.6 = ery Injury or other treumatic event, the Martine. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. Count Allegany Frostburg 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11615 Hoffman Hollow Road 21532 U.5,A Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: White Specify. 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Holsinger Jean Jaughteri9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brode Frostburg, mo 21532 11615 Hoffman Hollow Rd. Jean 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Porter Eckhart. Cemeter 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of F cility Durst Funeral Frostburg, Frost Ave. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronsmy **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ known Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate 1 Yes 2 No To the Hospital or Attending Physicien: After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Funerel Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21244 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nes

Registrar

4 Broadway Stra

Mary

M.D.

32. Angistrar's Signature

lan,

5 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician JOHN** EAGAN 05 14 2007 2035 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F Director 215-26-9237 July 03, 1929 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17101 Mount Savage Road, N.W. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: Kovea 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 ☐ Divorced 16b. Kind of Business in ustry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) a H construction engineer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other i any Injury or other traumatic event, tt state highway dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ C. Garrett Eagan Mary Cullen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Richard Way

20b. Place of Disposition (Name of cemetery, crematory or other place) Albert N. Via nephew LaVale Maryland. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Saint Michael's Cemetery Frostburg Maryland May 18, 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility oken Durst Funeral Home, 57 Frost Ave, Frostburg, MD 21532 23a. Part1 Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) **Physician** ORONARY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Que to for as a consequence off requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed to be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Hospital or Attending** 5 ☐ Pending investigation (Month, Day Year) Natural Natural Injury 1 ☐ Yes 2 ☐ No € ☐ Accident 24 hours after death Puneral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

9/10A 1120

> State Registrar

, MARJIT 31. Date filed (Month, Day, Year)

High

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 BISHOP 32 registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ANEXED of Maryland Pepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Yeer 4:20 A M Warren Robert Elliott 10 2007 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Home Frostburg Allegany 7. Age (In yrs. last birthday) II Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 21 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 € M 2 □ F 82 723-14-8945 Feb. 1925 Director Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or items 23s or 28s-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD. Allegany Barton Yos 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19110 Railroad St. 21521 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1√2 Yes 2 □ No WW 2 If Yes, Give Year or Dates: 1 Never Married 2004 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐ No white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Charcoal Manufacturer Foreman unknown other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Warren Elliott Ethel Pearl Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Ann Elliott/wife 19110 Railroad St., Barton, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 05/14/ 2007 cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Westernport, Maryland Department of Important: If any Injury or once. Philos Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home w w 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Hypertension about 10yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ed by the attending physicien and deteched for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4L-Unknown this certificete has been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 2 No 1 ☐ Yes within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 MAY 11 2007 026907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu 925 Bishop Walsh Rd, Cumberland, Maryland 32. Registrar's Signature 31. Date liled (Month, Day, Year) 2007

Registrar

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<u>E</u>	Page ment c ant: If ury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify							5/07	/2007	Fal.	ls Chu	rch,VA
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	Sta Regist		Charles W. Ka: 31. Date filed (Month, Day, Year) MAY 08 20	32 egis	trar's Signa				, ROC	V A T T	.те, М	עו, 2	20030	

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Baltimore	permit. Pag Department Important: I any injury o		21. 5 onature of Funeral Service Lice	evisee /	011	22	. Name and	d Addres	s of Facilit	y DeV	/ol Funer	al H	ome	
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9	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IF FEMALE:										11.	
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		n 2 Fetel death		Ectopic pre					23d	Date of delive	ery Day Year
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Division	or Att	Certification:	3 Suicide 6 Could not determined	286. Place of	Injury - At home, fa	arm, str	eet, factory,	office			28f. Location (Stre City or Town,	eet and N State)	umber or Rura	al Route Number,
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- 1	~	1	30. Name and address of person who		of death (Item 23a)	(Туре	rint)	20	12	201	SSELL USBU	41	Tilli	c
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DIV	Registr	ar no4	MAT U 8 21	307 King	ver st.	1	MIL!							

Registrar
DHMH 17 Rev 1/2001

State

4 Broadway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

8 2007

An

21244

Frastburg, Maryland

			State Registrar				Cei	rtificate	of L	Death	and Me	В	leg. No.	107	10424
			Decedent's Name (Fin	st, Middle,	Last)						2	2. Date of Dea	th		3. Time of Death
	Physici		Barbara Ann	n Fair	rfax							Month May 9	, ^{Day} 2007	Year	1:00 A. M
	/Medic Examin		4a. Facility Name (If not			mber)		4b. City, T	Town, or	Location o	f Death	iiu j		inty of Death	
	Lxaiiiii	CI	Garrett Co.					Oakla						rett	
-	Eumaral		5. Social Security Number		S. Sex	7. Age (In yrs.	. last birthday)	If Under 1		If Under 2	24 Hrs. 8	B. Date of Birth	1		nplace (State or Foreign
	Funeral Director		579-34-9354		1 ☐ M 2 🕱 F	78	Yrs.	Months	Days	Hours	Min.	(Month, Day ec 19,	Year)	Col	untry)
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	land		10a. State 10b	. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
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			For Amend Item #	State of Marylan	d / Dena	artment of I	Health and	Mental Hygi	ene	
			1- State Registrar WCHD/SH 5/			rtificate of			2007	16425
ŧ		套.	1. Decedent's Name (First, Middle, Las			······································		2. Date of Death Month		3. Time of Death
-45-	Physici /Medic		JULIA GOLDWYN	FARRELL				05/10/		1:36 a ^M
	Examir	er	4a. Facility Name (If not institution, give				or Location of Dea	th	4c. County of Dea	
7	C		The Village at Re		last hirthday)	Ha:	gerstown If Under 24 Hrs	8. Date of Birth		rington
	Funeral Director			□M 2ĂF 98	Yrs.	Months Days	Hours Min			rthplace (State or Foreign ountry)
	pu *		Usuat Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo					
	Maryla f eho	ō			y, TOWITOT LO					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-	Directo	West Virginia Berk 10e. Street and Number	eley		Falling 10f. Zip Code	waters	10	g. Citizen of What C	ountry?
	hours after death with the Maryland tural, or Itema 23a or 28a-f ehow al Examiner must be notified at	alD	371 Stayman Driv	e			25419			USA
	or dea	Juer	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	erican Indian,
30	rs afte	by Funeral	1 Never Married 2 Married 3 V Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1 ☐ Yes 次 (XNo			Specify:	
9500-6	in 72 hours after death with the Marylan "natural", or Itema 23a or 28a-f ehow tadical Examinar must ca notified at	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation	11	Sb. Kind of Business	White Alndustry
7	within 7 ene. than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) Coftege (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of wo d)	orking		•
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and	a a a a s	Be c	17. Father's Name (First, Middle, Last)	Ε!				me (First, Middle, Ma	,	
5	s 1 and 2 should f Health and Mer Itam 27 le marke other traumatic	ြ	Robert Wiley 19a. Informant's Name/Relationship (1)		19b. Mailir	ng Address (Street	and Number or R	nie Belle Tural Route Number	Moore City or Town, State	Zip Code) 25419
, Ma	and 2 : ealth ar n 27 le ler trau		Ruth Peyton - Daug	ghter	371	Stayman (Drive Fa	lling Wate	rs, West	Virginia
Š			20a. Method of Disposition 1 XBurial 2 Cremation 3		lace of Dispo emetery, crer	sition (Name of matory or other pla	ce)	Date 2	oc. Location - City of	Town, State
	ment of trant: If Its		4 Donation 5 Other (Specify	Wasi	hingto	n Nat. Co	em. May	14,2007 S	uitland,	Maryland
a C	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	6ee		b orne d four				21795
74			23a. Part1. Enterthe disease, or comp	plications that caused the death						, Maryland Approximate
	Physician		Immediate Cause (Finaf	one cause on each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. DEBILITY Due to (or as a consequence)	uence of):	70 SE	VILL DE	MEN71A		2 415
25	Examiner		Sequentially list conditions	b						
	pe #s	iner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
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۽ م	certificate Iding phys		fF FEMALE:							
X P		ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Fetal	death 3	Ectopic pregnanc	y		23d. Date of de	olivery Day Year
	he de the a	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□ Unknown	eath 5	Other (specify) _			Wichti	Day 1 dai
ŗ.	sician: The law requires that the death certificate has been signed by the atte rector, page 2 should be detached for		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
ecords,	quires en sign	ed by	CONONARY AR	TEMY DISTASE	٤			1 ☐ Yes	2 ₺ No 3 ₽	robably 4 Unknown
ဝ ၁	aw re as bec 2 sho	Completed	History ANTEN	OLATERAR WA	u M	YOCANDIA	INFAR	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	The tate has page	Com						performe	ed?/ death?	/
VIII H	ysician: is certific director,	Be	25. Was case referred to medicat examiner?	Hospitaf:		100	-	ath (Check only one,		
ō ;	ding Phys h. After this funeral dir	. To	1 ☐ Yes 2 ☑ No 27. Manger of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	3 DUA		Home 5 Residen		ecify)
Vision	Attending Physician: r death. sctor: After this certific by the funeral director,	ation:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □No	255. 50001150 1151	many occurred	
<u> </u>	r Atte er de; recto by th	Certificati	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
ַ ב	oltal o urs aft ral Di iled in									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medicai	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Example 2	ysicien: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the till vestigation, in my o	me, date and plac opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certifier	and marrier stated.		29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)
	_, ,		34 Atta \$	Ponato mo		Do	05/395		05/10/2	2007
1.	1 1-		30. Name and address of person who o	completed cause of death (Item	23a) (Type,	Print)			,	
21	1-5	1	31. Date filed (Month, Day, Year)	32. Registrar's Signal	MEDICAL	CAMPUS	Rs. 5417	=107 HA	661576WM	MD 21742
1	Sta Registr			007 Registrar's Signal	ture	lade.				

			1 - For State Registrar		laryland / Dep		Health and	F	giene leg. No. 0 0 7	16426
	Physici	an	Decedent's Name (First, Middle		mo			2. Date of Dea Month	Day Yea	3. Time of Death
	/Medic		Robert Lee		Foltz			May 9,		E'R, A M
	Examir	er	4a. Facility Name (If not institution,		")		or Location of De	ath	4c. County of De	
		~	21605 Leiter St			Hagerst			Washingt	
	Funeral		5. Social Security Number	6. Sex 7. A 1 M 2 □ F	ge (In yrs. last birthda) TE Yrs.	Months Days		n. (Month, Day		Birthplace (State or Foreign Country)
A,	Director		Usual Residence of Decedent		75 Yrs.			Jan. 10	1932 Mai	cyland
	and		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	fany fah	ō	M 1 1 77 - 1 1		77					1 ☐ Yes 2 ☐ No
	1he 1	Director	Maryland Washing	gron	Hagersto	10f, Zip Code			10g. Citizen of What	Country?
	with a or	ō		St.		21742			U.S.A.	obullity :
	leath	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S. 13		Hispanic Origin?	(Specify Yes or No-		nerican Indian,
	fter of the r	F	1 ☐ Never Married 2 ☐ Marri	Armed Forces	?	If Yes, specify Cub	an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	Black, W	
ဗ္ဗ	urs a	þ	3 Widowed 4 □ Divorced	ed 1 Yes 2 If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Vhite
21215-0036	n 72 hours after death with the Maryland "nature!", or fteme 23s or 28s-f show "alcal Exacting Invest to nytitled at	Completed	15. Decedent	s Education	16a. Dec	adent's Usual Occup	pation		16b. Kind of Busine	
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21	d within giene. er then	Ю	8	0011090 (1 401		e Maker			Book Manu	ifacturing
b	be filed tal Hygi d other event, ti	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's N	ame (First, Middle,	Maiden Sumame)	
<u>a</u>		2	Ralph Foltz				Mary	Bowers		
Maryland	d 2 should th and Men 7 is marke treumatic		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mai	ling Address (Street	and Number or I	Rural Route Numbe	r, City or Town, State	, Zip Code)
	1 and 2 Health : em 27 i		Wanda Lee Engli	sh	1485	Carrolls	s Track	Road Orr	tanna PA	17353
e e	thealifem 2		20a. Method of Disposition		20b. Place of Disp		1	Date	20c. Location - City	
Baltimore,	Pages nent of I int: if its ury or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 ∐Removal from State pecify)	Rest Have			2/2007 H	agerstown	, Maryland
三三	프트램		21. Signature of Funeral Service L						Funeral	
m	Dep Imp		1 m	15						aryland 21742
8760,	Physician who partial francial who partial francial the partial francial fr	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of): s a consequence of):	forthery	i4 D.T. 215 A			Myext
9	ng ph		IF FEMALE:							
P.O. Box	res that the death certifica signed by the attending ph be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o	delivery Day Year
ري ح	The law requires that the ate has been signed by th page 2 should be detache	by Pt	Part II. Other significant condition					23e. Did to	bacco use contribute	to the cause of death?
ĕ	w require been sig should b		Emph	750 mg				1 ∑ (Y	es 2 No 3	Probably 4 Unknown
00	s bee	jet	Pros	750 mg				24a. Was a	ın 24b Were	autopsy findings available
æ	The lav	Completed		CANE	47			autop: perfor	sy prior t med? death	o completion of cause of
a	ician: Th certificate rector, pag	Ö	25. Was case referred to medical					1 Yes	~	es 2 No
5	sceri	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ient 2 ER/Outpatie	int 3□ DOA Ott		eath (Check only or		
Division of Vital Records,	Attending Physician: r death. ector: After this certifica by the funeral director.		27. Manner of Death	28a. Date of Inju	ury 28b. Time		4 □ Nursing		ence 6 Other (S)	oecify)
on	th. Afte	텵	1 Accident 5 Pending 2 Accident investig		ay Year) Injury	Wor	rk? Yes 2∐No			
/isi	or Attendated after death Director: in by the	fice	3 ☐ Suicide 6 ☐ Could no	ot be One Disease to	njury - At home, farm, s			28f. Location (S	treet and Number or	Rural Route Number,
ă	afor after Dire	Certification;	4 Homicide determin	building, e	tc. (Specify)	,,		City or Tow		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	dicai	29a. Certifier (Clock only one) 1. Certifying 2 Medical E	Physician: To the best training: On the basis of and manner st	of examination and/or in	th occurred at the time timestigation, in my o	me, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
			1/1/1/	- BKen		8	7847		5/5/22	
		1	30. Name and address of person w		- de					
30	H1+1		William Kern	, 229,	death (Item 23a) (Type	son Blue	1 Smi	the bur	no ms	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature					
-	Registr		MAY 11	2007 Ban	m. A. D.	backs				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MAY 4, JACOB N. GROSS 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 CONNECTICUT AVENUE CHEVY CHASE MONTGOMERY 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 07/14/1915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 91 Director 328**-**07**-**5421 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1X Yes 2 □ No Director MONTGOMERY CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 CONNECTICUT AVENUE 20815 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERMAN GROSS EDNA JACOBSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD GROSS - son 4821 32nd Street, NW, Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐8urial 2 ☐ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) SHALOM MEMORIAL PARK 05/08/2007 ARLINGTON HEIGHTS. IL 21. Signature of unergloservice Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part. Enter the line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a CONGESTIVE HEART FAILURE YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infilibulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2√2 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Aatural 5 Pending investigation Injury 1 Tyes 2 No nerei Director: / rilled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗋 Homicide within 24 hours e To the Funerei cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Certifie 29c. License number 29d. Date signed (Month, Day, Year) D32033 May 4, 2007 mm D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PETER G. HAMM, 5530 WISCONSIN AVENUE, CHEVY CHASE, MARYLAND 31. Date filed (Month, Day, Year) 32 Registrar's Signature 0 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 200^{Year} **Physician** 3, May 11:25 PM C GOODING WTT.T.TAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months 1 X M 2 □ I Maryland Director 220-32-5969 70 Aug. 14, 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 No Director Maryland Frederick Mt. Airv 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 21771 7713 Harvest Hills Court Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. 2 🔀 No 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify: þ 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Manager Wine Importer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Preston Forrest Gooding, Sr. Alice Virginia Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Helen E. Gooding / Wife 7713 Harvest Hills Court Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 7, 2007 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 21. Sig ture o Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3-4 Day 3 Dneumonia Due to (or a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

28a-f show

filed within 72 hours after

and Mental Hygiene. Is marked other than

Pages 1 and 2 should be finent of Health and Mental I

altimore, Maryland 21215-0036

physician and s the burial-trans attending p for use as as signed by the a peen certificate has

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Division or Vital Records, P.O. Box 68760,

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Physician/Medical à Be Completed ٩ To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Atrial Fibrilation 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an portansion autopsy performed 2 No probravascular 2 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) Hospital: Inpatient 2 [28a. Date of Injury (Month, Day Year) 1 ☐ Yes ➤ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Naturai 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hiron of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tredorick mp Thomas

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMENDITEM 7 Per EH G869-7/26/07 Wand Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Manth Elmer (unk) Greenhawk 238 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/09/1924 Birthplace (State or Foreign Country) 1**X**|M 2□ F Months Days Hours Min 82 Yrs 220-26-7846 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Hagerstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 21742 10g. Citizen of What Country? 14014 Marsh Pike US 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No White Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmhand Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jonas (unk) Greenhawk Florence (unk) Davenport 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1195 Avondale Court, Frederick, MD 21703 Patricia A. Fuss / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg Crematory 05/08/2007 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that cause in shock, or heart failure. List only one cause on each line me death. Do not enter the mode of dving such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cul Renal Due to (or as a consequence of): clostridium Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death Month Day Year □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Completed by Funeral

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Jry or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Physician/Medical

Completed

Be

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Medical

Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; Atter this certifica

Division or Vital Records, P.O. Box 68760.

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State Registrar

1 | Yes 2 | No 27. Manner of Death 1 Natural

29b. Signature and title of certifier

31. Date filed (Month, Day,

29a. Certifier

2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide

5 ☐ Pending investigation

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 1)0603

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUR

SHED 10 2007

and manner stated.

32. Registrar's Signature

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			For State Registrar	State of Marylan		artment of F rtificate of				
			Registrar 1. Decedent's Name (First, Middle, L.	act)	Ce	Tillicate of		2. Date of Death	g. No. 200	3. Time of Death
п	Physici		Stephen	Griffiths				Month (25	Day Year	2246PM
	/Media		4a.,Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death	03	4c. County of Dea	
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-	Funeral			Sex 7. Age (In yrs.			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
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	the N 28a-f	Director	MD Worces 10e. Street and Number	ster Uce	an Cit	10f. Zip Code		10	g. Citizen of What C	ountry?
	with 3a or 1 be r		11500 Coastal Hi	ighway, Unit 11	8	21842			USA	
	ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U		Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
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yla		은	James Griffith				Ruth Ed			
Maryland			19a. Informant's Name/Relationship			,			City or Town, State,	
	1 an Heal		Audrey H. Griff	20h I	Place of Disn	osition (Name of	i		City, Md. 20c. Location - City of	
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n or	U + Q		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	iry at ork?	28d. Describe ho	w injury occurred	
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31. Date filed (Month, Day, Year)
MAY 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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İ	Physici /Medic		1. Decedent's Name (First, Middle, La James Paul Gray	st)			·			2. Date of De Month 05/08/	ath	ıv Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. S 577-40-4100 Usual Residence of Decedent	VM4 2FTE	ge (In yrs. last birth 78 Y		Under 1 Year nths Days	Hours	Min.	8. Date of Bir (Month, Da 01/25/1	iy, Year,	Cou	place (State or Foreign ntry) Ington, DC
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any fujury or other traumatic event, I'm Medical Examinal must be notified at ancase.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Types 2 C If Yes, Give Year or Dates	s?] No	If Yes		an, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: White	etc.
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, Mary	and 2 shoulaith and N		19a. Informant's Name/Relationship (**								or Town, State, Zij MD 21811	Code)
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	To the Hospitel or Attenk within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	nysician: To the bes miner: On the basis and manners	of examination and	death occ	gation, in my	opinion, dea	nd place, ath occurr	and due to the red at the time,	date an	d place, and due t	o the cause(s)
)	To To	2	29b. Signature and title of certifier	ional mo	>			se number	307		May 1	y 8, 200	
B	A 10+1	ate	30. Nameland address of person who T. Vom Eq. mand MC 31. Date filed (Mohah, Day, Year)	, 9733 H	1.1	Type, Print	- I.	1, MD	218	11			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Hoskins, Jr. Mathias Deming 04:16 AM May 15 20e7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day,) 1/8/1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1√2 M 2 □ F West Virginia 216-32-9884 76 Director Usual Residence of Decedent 10a State 10c, City, Town or Location 10d. Inside City Limits 10h County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2X No Director Churchville MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2903 Kragel Dr. 21028 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Exa<u>miner must</u> 12. Was Decedent Ever in U.S. Armed Forces? SELYes 2 □ No If Yes, Give Year or Dates Korea Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cable Shop Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mathias Deming Hoskins, Sr. Catherine G. Profit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendell R. Hoskins (Son) 68 Black Oak Trail Delta, PA 17314 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 5/18/07 Aberdeen, Maryland 22 Name and Address of Facility
Tarring-Cargo Funeral Home, P
Thordeon Maryland 21001-3399 21. Signature of Funeral Service Licensee sies 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** Myocardial 1 day /Medical Due to (or as a consequence of): Examiner Coronary Ar Due to (or as a consequence of): Artery Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, physician at the burial Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) P.O. I signed by the a □Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 LNG 1 ☐ Yes 1 Dinpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Hospital or Attending 5 Pending investigation 1 Watural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

DHMH 17 Rev 1/2001

Registrar

13.4

29a. Certifier

(Check only one)

29b. Signature and title of certifier

WALID

MAY 2 1 2007

31. Date filed (Month, Day, Year)

Medical

and manner stated.

M.D.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBOUR

M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

HT 243 89 46

Union Memorial Hospital.

May 15, 2007

1 - For State Registra 1. Decedent's

Funeral Director

Completed by

Be

မှ

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

219-54-1235 1	ampus 7. Age (In yrs. In 53 10c. City Is Decedent Ever in U.s	Yrs.	4b. City, T Cur If Under 1 Months	nd Hour	der 24 Hrs.	2. Date of Death Month 8. Date of Birth (Month, Day, Y NOV 5, 1	ear) l	O:OOP ^M
Facility Name (If not institution, give street a WMHSBraddock Cascocial Security Number 6. Sex 1	ampus 7. Age (In yrs. In 53 10c. City Is Decedent Ever in U.s	ast birthday) Yrs.	4b. City, T Cur If Under 1 Months cocation mberlai	mberlan 1 Year If Und Days Hour	der 24 Hrs.	8. Date of Birth	4c. County of De Allegan	eath Sirthplace (State or Foreign
WMHSBraddock Ca Social Security Number 219-54-1235 ual Residence of Decedent a. State MD Allegany b. Street and Number 613 Lynn Street Marital Status Never Married 2\(\) Married H \	Tampus 7. Age (In yrs. In 53	Yrs.	Cur If Under 1 Months	mberlan 1 Year If Und Days Hour	der 24 Hrs.	(Month, Day, Y	Allegan	y Birthplace (State or Foreic
6. Sex 1	7. Age (In yrs. In 53 10c. City specedent Ever in U.s. 1979 1982 2 内 No	Yrs.	If Under 1 Months cocation nberlai	1 Year If Und Days Hour	der 24 Hrs.	(Month, Day, Y	9. B	Birthplace (State or Foreig
219-54-1235 Sual Residence of Decedent	10c. City 10c. City s Decedent Ever in U.s med Forces?	, Town or Lo	nberlar	nd	rs Min.	Nov 5, 1	953	MD
MD Allegany e. Street and Number 613 Lynn Street . Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes	is Decedent Ever in U.s ned Forces?] Yes 21점 No		nberlar					
MD Allegany e. Street and Number 613 Lynn Street . Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes	is Decedent Ever in U.s ned Forces?] Yes 21점 No		nberlar					10d. Inside City Limits
e. Street and Number 613 Lynn Street Marital Status Never Married 2\(\) Married 1 1 1 1 1 1 1 1 1	ned Forces?]Yes 2⊠No		10f. Zip (1 √Yes 2 No
Marital Status 12, Wa Arri 1 □ Never Married 2 ☑ Married 1 ☐ If Y 3 □ Widowed 4 □ Divorced Yea	ned Forces?]Yes 2⊠No			Code		10g	. Citizen of What	Country?
. Marital Status 12, Wa. Arri 1 □ Never Married 2 Married 1 if Y 3 □ Widowed 4 □ Divorced Year	ned Forces?]Yes 2⊠No			21	502		USA	4
3 ☐ Widowed 4 ☐ Divorced Yes		S. 13.	Was Decede	ent of Hispanic ify Cuban, Mex	Origin? (Spe ican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
	es, Give ar or Dates:		1 ☐ Yes 2				Specify:	white
		16a. Dece	dent's Usual	l Occupation		16	b. Kind of Busines	
(Specify only highest grade comp	pleted) llege (1-4or 5+)	(Give life.	kind of work DO NOT use	k done during n e retired)	nost of workir	ng		•
12	- , /	bus o	driver				Friends A	ware
Father's Name (First, Middle, Last)	ot Cr					(First, Middle, Ma		
Joseph W. Hayhurs 9a. Informant's Name/Relationship (Type. Prin		19h Maili	ina Address			Route Number, C		e. Zip Code)
Brenda Hayhurst	wife			Street	moer or read	Cumb		MD 21502
a. Method of Disposition	C	lace of Dispo	osition (Namernatory or ot	ne of	D	ate 20	c. Location - City	or Town, State
1 ☐ NBurial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	u trom State I _		orial Ce			5/17/2007	Cumberl	and MD
1. Signature of Funeral Service Licensee	llle	. 2		d Address of Fa carpelli Fur 08 Virginia		ne, PA Cumberland	, MD 21502	
3a. Part1. Inter the disease, or complications shock, or heart failure. List only one caus	s that caused the death se on each line.	. Do not en	ter the mode	e of dying, such	as cardiac o	r respiratory arres		Approximate Interval Between
nmediate Cause (Final isease or condition	Arterioscl	leroti	c Hear	rt Dise	ase			Onset and Death
esulting in death)	Due to (or as a consequ	uence of):						
equentially list conditions, b	Due to (or as a consequ	uence of):						
ause. Enter Underlying ause (Disease or injury		/-						
nat initiated events c esulting in death) Last	Due to (or as a consequ	uence of):						
d								
FEMALE:								
3b. Was decedent pregnant in the past 12 months?	res, outcome pf pregna □Live birth 2 □ Fetal □Pregnant at time of de □Unknown	death 3	□Ectopic pre □ Other (spe				23d. Date of o Month	delivery Day Year
art II. Other significant conditions contributing	ng to death but not resu	ulting in the u	underlying ca	ause given in Pa	art I.	23e. Did toba	cco use contribute	e to the cause of death?
						1 □ Yes	2 □ No 3 □	Probably 4 Unknow
						24a. Was an	24b. Were	autopsy findings availab
	-					autopsy performe 1 Yes 2	prior 1	to completion of cause of
5. Was case referred to medical				26. P	lace of Death	(Check only one)	101	
examiner? No Hospital	ll: 1 ☐ Inpatient 2	ER/Outpatie			Nursing Hor	ne 5□ Residen	ce 6 □Other (S	pecify)
Natural 5 ☐ Pending	. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury at Work?		28d. Describe how	injury occurred	
2 Accident investigation 3 Suicide 6 Could not be determined 28e	. Place of injury - At ho building, etc. (Specify		M treet, factory,	1 ☐ Yes 2 , office		28f. Location (Stre City or Town,		Rural Route Number,

0 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Paul Snow M.D 32 Registrar's Signature MAY 2 1 2007

of person who completed cause of death (Item 23a) (Type, Print)

124 W. 3rd Street Cumberland MD 21502

D09157

29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

#208 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravi Passi MD. 15225 Shady Grove Road,

08

31. Date filed (Month, Day, Year)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State of Mar Registrar		rtment of Hea tificate of De		lental Hyg	ene	
3.		1. Decedent's Name (First, Middle, Last)	Cei	inicate of De	alli	2. Date of Deat	g. No.	3. Time of Death
Physicia /Medic		Arnold R. Hutt				Month May	3, 200	
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County of Dea	
*) [2]	2	Alfred House Assisted Living 5. Social Security Number 6. Sex 7. Age		Rockvi		0.0.4 (0.4)	Montgo	
Funeral Director		5. Social Security Number 6. Sex 7. Age 578−30−5114 2 F Usual Residence of Decedent	(In yrs. last birthday) 80 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 24	Year) 9. Bir Co 1926 Wasl	thplace (State or Foreign ountry) nington, D.C
/land ow			10c. City, Town or Loc	ation				10d. Inside City Limits
a-f sh	ctor	Maryland Montgomery	Silver S	pring				1 X Yes 2 □ No
ith the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
s 23a		15101 Interlachen Drive, #		2090			U. S. A.	
and 21215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates;	Navv	/as Decedent of Hispa Yes, specify Cuban, № Yes 2 🏋 No Si	inic Origin? (Spe Mexican, Puerto <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
2 hou	ted	15. Decedent's Education	16a. Deced	ent's Usual Occupation	n		6b. Kind of Business	Industry (Industry
21215-0036 ed within 72 hours af gjene. er than "natural", or the Medical Exami	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	aind of work done during ONOT use retired)	ng most of worki	ng		
N p b t		12 Years	Mer	chant			Liquor	
Maryland Id 2 should be file Ith and Mental Hy If is marked oth traumatic event	Be	17. Father's Name (First, Middle, Last)				(First, Middle, M	•	
farylan 2 should be and Mental is marked o	မ	Harry Hutt 19a. Informant's Name/Relationship (Type. Print)	19b Mailin	Address (Street and		iedenber	<u> </u>	Zin Cada)
orher trau		Goldie F. Hutt - Wife	15101	Interlach	en Dr.,	# 108,	Silver Spi	cing, Mdo6
Ore, esta of He fitem		20a. Method of Disposition	20b. Place of Dispos	ition (Name of atory or other place)			Oc. Location - City or	
Page ment annt la uny o		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (<i>Specify</i>)	Mount Leb		5/6/2	007 A	delphi, Ma	aryland
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	Ed 10	Name and Address of Ward Sage 1 91 Rockvil	Facility Funera 1e Pike	l Direct , Rockvi	ion, Inc. Ile, Mary	Land 20852
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a. Due to (or as a condition of the cause o		son's Dise		. Toophadory and	0.1	Approximate Interval Between Onset and Death
BOX 08/0 eath certificate be attending physicial for use as the burner.	by Physician/Medical E	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but	☐ Fetal death 3☐ me of death 5☐	Ectopic pregnancy Other (specify)	n Part I.	23e. Did toba	23d. Date of del Month	Day Year
equire	ed b					1 ☐ Yes	s 2□No 3□Pr	obably 4 Xunknown
VITAL RECONDS, P.O. sician: The law requires that the descriticate has been signed by the rector, page 2 should be detached	Completed					24a. Was an autopsy perform 1□ Yes X	prior to death?	topsy findings available completion of cause of 2 ☐ No
VIII sicertii irecto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	OF FRIOutpations	Other		(Check only one		
or Attending Physician: The sifer death. Director: After this certificate he in by the funeral director, page	ition: To	27. Manner of Death 1	2 ER/Outpatient 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	2	ne 5 ∐ Resider 28d. Describe hov		cityGroup Home
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director,	Certification:	a□ Puiside 6□ Could not be	- At home, farm, stre (Specify)	et, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
To the Hospital within 24 hours of To the Funeral completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state	xamination and/or inve	occurred at the time, destigation, in my opinion	date and place, a	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To th Withir To th comp	Me	29b. Signature and title of certifier		29c. License nur	mber	29	d. Date signed (Monti	n, Day, Year)
6		Eynthia m Million	ms	H00580	032		may 4, 2	1007
U		30. Name and address of person who completed cause of deal Cynthia M. Williams, M. D. 6	th (Item 23a) (Type, P 50001 Munc	rint) aster Mill	Road, 1			
Stat Registra		31. Date filed (Month, Day, Year) MAY 0 8 2007 32. Jegistrar's	s Signature	ruff p				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:45 A.M 2007 Marguerite Marie Harrison May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14401 Traville Gardens Circle, # 309 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖾 F Director 126-18-5610 82 August 16,1924 NY Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 2 should be filed within 72 hours after death with the Marylar and Mental Hyglene. It is markental Hyglene Is markent than "natural", or items 23a or 28a-f show Is marken other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14401 Traville Gardens Circle, # 309 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 2 Specify. 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Inportant: If item Z7 Is marked oth any Injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Be Marguerite ၉ Wallace Kennedy Hyland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Monahan/Daughter 16803 Camberford Street, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 5/7/2007 |Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Sign tute of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician <u>As</u>thma Years /Medical Due to (or as a consequence of): **Examiner** b Morbid Obesity Years Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed Exami Hypertension 5 Years and burial-trar Due to (or as a consequence of): physician sthe burial Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page perform this certificate 2 X No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2**7** No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1X Natural 5 Pending ours after death.

neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospitai 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brigitte Abrishami, M.D., 11904E Darnestown Road, North Potomac, Maryland 20878 egistrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 8 2007

DHMH 17 Rev 1/2001

Registrar

			for State Registrar	State of Ma	arylan		artmen rtificat			d Mental H	ygien Reg. N	2007	1543
	Physic	ian	1. Decedent's Name (First, Middle, I	_		14				2. Date of Month	D	ay Year	3. Time of Death
	/Medi Examii		Lilias 4a. Facility Name (If not institution, g 104 Forest Dri			MacF	4b. City,	Town, or	litz Location of D rland	Month May	14	2007 c. County of Death	8:12 A M
	Funeral Director		5. Social Security Number 6. 060-01-6004	Sex 7. Age	e (In yrs. 93	last birthday) Yrs.	If Under Months		If Under 24 I	Hrs. 8. Date of I (Month, 103 / 08	Birth Day, Year		lace (State or Foreign
	show show	'n	Usual Residence of Decedent 10a. State 10b. County MD Alle		10c. Cit	y, Town or Lo						1	0d. Inside City Limits
	with the N a or 28a-f	Director	MD Alle			C	umber 10f. Zip		21502		10g. C	itizen of What Cour	11X1Yes 2 □ No htry?
9600	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		- 1	Was Deced f Yes, spec I □ Yes 2			(Specify Yes or I uerto Rican, etc.)	No-	14. Race - Americ Black, White,	
1215-(within 72 h ene. than "natu te Medica	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5	+)	10-00	kind of wor OO NOT us	k done d e retired)	tion uring most of	working		Kind of Business/Ind	lustry
Baltimore, Maryland 21215-0036	should be filed or and Mental Hygie s marked other i umatic event, th	To Be Co	12 17. Father's Name (<i>First, Middle, Las</i> William	(NMN)	 Ma	cFie	<u>Cleri</u>		18. Mother's N	Name (First, Midd		,	cKenzie
Mary	1 and 2 shoul Health and M lem 27 Is marl other traumati	Ĕ	19a. Informant's Name/Relationship Kenneth W. MacFi	(Type. Print)		19b. Mailin			nd Number or		ber, City	or Town, State, Zip	
more,	Pages 1 a nent of Hez nt: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from State	20b. P	lace of Disposemetery, cren	sition (Nam natory or of	e of her place)	Date / 18/2007	20c. L	ocation - City or To	
Balti	permit. Departm Importar any inju									Adams Far	ily		Home, P.A. 21502
9/90,	Physician / Medical Examiner the prival-transit the prival-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List online mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c. Due to (or as a d.	a consequ	ience oi):				sewih	,	veadly.	Approximate Interval Between Onset and Death
.O. BOX 8	To the Hospital or Attending Physician: The law requires that the death certification 24 horars after death. To the Funeral Director: After this certificate has been signed by the attending placompletely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director, page 2 should be detached for use as the state of the funeral director.	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal	death 3□	Ectopic pre Other (spe					23d. Date of deliver	y Day Year
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	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	(Month, Day	Year)	Injury	М		es 2 No	28d. Describe			
Ś	spital or ours after neral Dire		29a. Certifier ⊅ Certifying P	building, etc.	(Specify)	vledge death	occurred a	the time	date and nia	City or 10	wn, State		
	the Ho lin 24 h the Fu tpletely	Medical	one)	miner: On the basis of e	examınatı	on and/or inve	estigation, i	n my opi	nion, death oc	ccurred at the time	, date and	d place, and due to	the cause(s)
	2 15	2	29b. Signature and title of certifier		n	1	29c.	License r	573		29d. Dat	te signed (Month, D	ay, Year)
	nes		30. Name, and address of person who	completed cause of dea	ath (Item :	23a) (Type, P	rint)	, (OL	0./	Y	1/1/	1 Ima
Ü	Stat Registra		31. Date filed (Month, Day, Year)	B2/Registrar	's Signatu	ire			ian (2160	1000160	21 (11)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month May 200⁷7° **Physician** 10, 2:15 Hilda Margaret Ам Haberkorn /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Washington Julia Manor Health Care Center Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth July 5, 1909 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖸 F Maryland 97 213-36-2885 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23s or 28s-f show other treumatic event, the Modical Examinar must be notified at 1X Yes 2 No Maryland Directo Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 8-G Oak Tree Lane 21795 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department Manager Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Kuhlman Henry Lillian Genevieve Carle ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is n any injury or other treum 2006. Virginia P. Cook Daughter In Law 8319 Old National Pike, Boonsboro, Md. 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State |Hagerstown Crematory | 05-11-07 * 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home Inc. 40 East Antietam Street, Hagerstown, R. heel Brao Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician kr as a consequence of): disease or condition resulting in death) /Medical Dun to **Examiner** el Covaly VINOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 🙀 No Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 21 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 052323 5-10-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 05H-7 Khalid M. Waseem M.D. 1126 Opal Court, Hagerstown, Maryland 21740 31. Date filed (Month, Day, Year) MAY 10 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🦠 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Robert Earl 2007 Hampton Jr. May 2:58 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 1, 1946 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Washington, DC 579-58-6890 61 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ns 23a or 28a-f show must be notified at TTYes 2 No Carroll Mt. Airy Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21771 316 Violet Court "natural", or items 23a Funeral 12. Was Decedent Ever in U.S.
Ammed Forces?
12. Wes 2□ No
If Yes, Give
Year or Dates: Viet Nam 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. event, the Medical Examiner 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) US Postal Service Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be find and Mental His marked of permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumating. Hampton, Jr. (Unknown) Mary Kay Earl Robert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt. Airy, MD 21771 316 Violet Court, Kay Hampton/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cheltenham VA Cemetery5/10/2007 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Fureral Service 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part lender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. Vist only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC UNIC CARCINOMA

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** WEEKS to MOUTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

31. Date filed (Month, Day, Year) 9 2007

29b. Signature and title of certifier

(Check only one)

egistrar's Signatury

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1)26499

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	arylan		artment of rtificate or		and Me	ental H		ne No 200	7 16	140
Į	Physici /Medi		1. Decedent's Name (First, Middle JOHN	, Last) FABER	JO	HNSON	, JR.			2. Date of I Month 1AY	Death	Day 2007 Year	3. Tim	e of Death
	Examir	ier	4a. Facility Name (If not institution, 18612 MUNCAST	ER ROAD				WOOD				4c. County of D	ERY	
	Funeral Director		5. Social Security Number 579-24-6950 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. 79	last birthday) Yrs.	If Under 1 Yea Months Days		Min.	B. Date of E (Month, I July	Day, Y	ear)	Birthplace <i>(Sta</i> Country) .shingt	
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	th with the 23a or 28 ast be not	Funeral Director	10e. Street and Number 18612 Muncaster	Road			10f. Zip Code	208	355		10g.	Citizen of What United	,	S
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 25 Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		gin? (Spec i, Puerto R	ify Yes or Nican, etc.)	No-	14. Race - Ai Black, W Specify:	merican Indiar hite, etc. White	,
Maryland 21215-0036	ed within 72 h /giene. er than "natu i, the Medical	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	s Education grade completed) College (1-4or 5	+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retir urneyman	e during most ed)			168	Constru		
yland	ould be file Mental Hy arked oth atic event	To Be (17. Father's Name (First, Middle, L	ohnson, Sr.			_	1	r's Name (ephir			_{den Surname)} Lina		
, Mar	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationsh Teresa T. Johns			19b. Mailii 186	ng Address <i>(Stree</i> 12 Munc a	tand Number ster R	r or Rural Road,	Route Num Derwo	ber, C	ity or Town, State Md. 2	o, Zip Code) 0855	
Baltimore,	Pages 1 tment of H tant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	0	emetery, crei	osition (Name of matory or other pla Heaven C	´ ;	5/9/			Location - City Silver S	,	
Ba	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	1. Barber			2.Name and Addr Muriel H P.O.B	ox 503	8, Lā	ytons	svil	lle, Md.	20882	2
58760,	the death certificate be executed Wedical Exam The attending physician and and inched for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a d. Due to (or a) d. Due to (or a	a consequ	uence of):	CC	ing, such as c	cardiac of I	respiratory	arrest,		Approxin Interval Onset ar	3etween
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n	7/		29b. Signature and title of certifier	e Wroll	Ew	£ in		0 6 4 c	6 15		29d.	Date signed (Mor	7	
1	Sto		30. Name and address of person w <u>Genevieve</u> 31. Date filed (Month, Day, Year)	Wroblev	ath (Item USK r's Signati	i m]		5 Pic	car	d Z	dr,	Roc	KVIll	20851 e mi
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician 2607 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 Cand Medical Ge larca more None Min. 8. Date of Birth (Month, Day, You Sept 12, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 9. Birthplace (State or Foreign **Funeral** ^{Year)}1927 Days Months 1 **2**M Hours Mary Land 218 22 3869 79 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State r 28a-f show notified at 10d Inside City Limits show 1 ☐ Yes 2 No Director MD Carroll Union Bridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ns 23a or 7 must be r 21791 538 Shriner Court United States Funeral death 'natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: \ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 Divorced WWII White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) unknown Construction Worker Commercial Construction traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F Howard G. Johnson Mattie unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Department of Health Important: If Item 27 any injury or other troonce. Lottie Jeanette Johnson/Wife 538 Shriner Court Union Bridge, MD 21791 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □Removal from State Greenmount Cemetery 5-9-2007 Manchester, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 allus 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bacteremia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Junknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 □ No 1□ Yes 2 100 1 TYes Attending Physician: 25. Was case referred to medical examiner? Be (26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1-Natural 5 ☐ Pending investigation Injury 1 Tes safter death. 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or To the Hospital of within 24 hours at To the Funeral D 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) X1 00 person who completed cause of death (Item 23a) (Type, Print) Name and address of

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State Registrar reakle

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31. Date filed Month, Day, Year)

DHMH 17 Rev 1/2001

32. Pigistrar's Signature

Baltimere

			1 - For Stete Registrer	State of M	/larylan		artment rtificate			and M	ental Hy	giene	7 11	07	15442
H	Physici		1. Decedent's Name (First, Middle, Las Philip Price Jo	nes							2. Date of De Month May 3,		37	Year	3. Time of Death 7:00 P M
1	/Medic Examin		4a. Facility Name (If not institution, give Hill Haven Nursin		or)		4b. City, T Adelp		Location o	f Death		4c	. County		rge's
	Funeral Director		5. Social Security Number 6. S 547-40-3747 1 Usual Residence of Decedent	ex 7., X M 2□F	Age (In yrs. 82	last birthday) Yrs.	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, Di Aug 11	rth ay, Year)	24	9. Birthpi Coun Chin	lace (State or Foreign try) a
	Maryland a-f show	ctor	10a. State 10b. County MD Montgome	ry		y, Town or Lo								10	0d. Inside City Limits 12 Yes 2 □ No
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036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f show raumatic avent, the Marylea Examinar must be inclified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decede Armed Force 1X Yes 2 If Yes, Give Year or Date:	s? ∃No			ent of His fy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ocify Yes or No Rican, etc.)			- Amenc k, White, (etc.
Baltimore, Maryland 21215-0036	within 72 ho ene. then "netur to Medicel	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4c	r 5+)	(Give life. l	dent's Usual kind of work DO NOT use rch At	done d retired)	u <i>ring</i> most	of workii	ng		ind of Bu	isiness/Ind	lustry
2	filed Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Francis Price Jon			Resea		Ī	18. Mothe		(First, Middle	, Maider	Sumame		
Mary	nd 2 sho alth and h 27 is ma ir trauma		19a. Informant's Name/Relationship (Peter Jones/son	Type, Print)			g Address (Tresco				<i>I Route Numb</i> coma Pa				Code)
more,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any Injury or other traumatic av once.		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control o			lace of Dispo emetery, cren sapeak					6/07			City or To	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licer	e atte	MO						Servi				784 MD 21029
	certificate be executed ding physician and lase as the burial-transit	dical Examiner	23a. Part1. Enter the dispasse, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Securitally list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Nosocon Due to (or a b. Parkins Due to (or a	line. nial P as a consequ	neumon Jence of): Diseas Jence of):	ia				r respiratory a	irrest,			Approximate Interval Between Onset and Death
ă.	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pred Other (spec						23d. Date Mon	e of delive	ry Day Year
a .	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of Hypertension, Ost					-	n in Part I.						e cause of death?
r	The ate h page	Completed by									24a. Was auto perfe 1 ☐ Yes		p d	rior to con eath?	osy findings available inpletion of cause of 2 No
	tician: Tr certificate rector, pa	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only				
5	Attending Physician: r death. ector: After this certific by the funeral director.	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		ER/Outpatien 28b. Time of Injury		c. Injury Work	at ? es 2 □ N	2	ne 5 Resi 28d. Describe)
	2 th 2 th 3	Certification:	3 Suicide 6 Could not by determined	280. Place of I	njury - At ho etc. <i>(Specif</i>)	me, farm, str	eet, factory,	office		2	28f. Location (City or To			er or Rura	l Route Number,
	5 t 5 8	Medical	(Check only 2 Medical Exen	ysician: To the be- niner: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred at restigation, in	t the time	e, date and inion, deat	d place, a h occurre	and due to the ad at the time,	cause(s date and) and mar d place, a	nner as sta	ated. the cause(s)
•	To the P To the F complete	Σ	29b. Signature and title of certifier.	HD				License	number				te signed		Day, Year)
\mathcal{L}	ad		30. Name and address of person who Thomas E. Maslen,					er D	rive	Gree	enbelt,	MD	2077	0	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 2		strar's Signa		last i								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Mae Shirlev Jackson 3, 2007 3:15 P May /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Severna Park Center Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 77 Director New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 Edge Creek Lane 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) George Winfield Daisy Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtne K. King/daughter 227 Edge Creek Lane Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 03/05/07 Beltsville, MD 21. Signatore of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastati langioca Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 more Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has bairector, page 2 s To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred Certification: 1 tural 5 Pendina 1 ☐ Yes 2 ☐ No death. Accident investigation the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, az rans Hwy Millors M 860 QN KIRD ING 31. Date filed (Month, Day, Year) gistrar's Signature State MAY 0 8 2007 Registrar

			se Type or State of	of Manulan	d / Dep	artment of	Health	and N	-		egible.	, 1 1 1
		1 = For State Registrar AMEND#8per:		MW,Mcco	Ce	rtificate o	t Death)	2. Date of De	Reg. No.	2007	3. Time of Death
Physicia			dichael J. N	Kubisiak					Month	2, Day	Year 07	6:15 p ^M
/Medic Examin		4a. Facility Name (If not institution				4b. City, Town	or Location	of Death	,		County of Death	1
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Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	Vro	Months Day		r 24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y.1Y2ar)</i>	Cot	nplace (State or Foreign untry)
Director		399-12-9800 Usual Residence of Decedent		81					February	26,19	26 Wisc	consin
/land ow at		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
Mari a-f sh ified	tor	Maryland Monts	gomery			Silver Spi	ing					1 □Yes 2 No
th the	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	untry?
ath wi		3005 South Leisure					20906					S.A.
er de Items	Funeral	11. Marital Status	Armed F		S. 13.	Was Decedent of If Yes, specify C	f Hispanic Or uban, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	0- 1	 Race - Amer Black, White 	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire X7 Is marked other than "natural", or Items 23a or 28a-f show important: If the MZ Is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at once.	by F	1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2□No iive Dates: WWII		1 ☐ Yes 2 🗷 🔻	o <i>Specify</i>	<i>'</i> :			Specify:	White
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should nd Me mark matic	P .	19a. Informant's Name/Relations	eter Kubisi Ship (Type, Print)	ak	19b. Maili	ng Address (Stre			ine Brzo: rai Route Numb			in Code)
nd 2 salth ar 27 is 27 is r trau		Ellen Fahey Kul		ouse								, MD 20906
item item othe		20a. Method of Disposition		20b. F	Place of Disp	osition (Name of matory or other p	t		Date		ation - City or	-
Page nent a		1 ☐ Burial 2 【3 Cremation 4 ☐ Donation 5 ☐ Other (5		n State		n Cremato	1	5/8/	2007	Brent	wood, Mai	yland
permit. Departr Importa any Inj		21. Signature of Funeral Service	Licensee		2	2. Name and Add	ress of Facil	lity eral B	lome. Inc	_		
90 E 8 9		tours	Men	au-	1	1800 New I	lampshir	re Ave	nue, Sil	ver Sp	ring, Man	yland 20904
		23a. Part1. Enter the disease, o shock, o heart failure. Lis Immediate Cause (Final	t only one cause on	each line.	n. Do not er	ter the mode of c	ying, such a	s cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	oronary Ar		sease						
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<u>a</u> □ e	Ш	resulting in death) cast	Due to	(or as a conseq	uence ot):							
The law requires that the death certificate be e. ate has been signed by the attending physician bage 2 should be detached for use as the buria	dica		d									
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death s atter d for u	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 🔼 No	4□Preg	birth 2□Feta gnant at time of d		⊒Ectopic pregna ⊒ Other (specify)					Month	Day Year
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g Phy erthis eral c	n: To	27. Manner of Death	28a. Date		28b. Time o		jury at ork?	idising m	28d. Describe			y) -
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or Atterdering in by the	Certification:	3 Suicide 6 Could 4 Homicide detern	ningd 200. Flat	e of injury - At ho ding, etc. <i>(Specif</i>	ome, farm, st	reet, factory, offic	е			(Street and wn, State)	l Number or Ru	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, I		200 Codifica 155 Codifici	no Dhuaisiana To th	a host of my kno	wledge dee	th cooursed at the	time date a	and place	and due to the			
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DHMH 17 Rev 1/2001

			For State Registrar		State of	of Maryla			t of H	lealth a		•		007	164	45
5	Physici		1. Decedent's Name (First, I	Middle, La	st) KLE	IN						2. Date of De Month	Day	Year	3. Time of 11:38	
1	/Medio Examir		4a. Facility Na <i>me (If not insti</i> 8900 Fernwoo			ımber)			Town, or	Location o		May 3,	4c. C	ounty of Deal	th	
production.	Funeral Director		5. Social Security Number none		Sex 1□M 2 火 □F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Bi April Date D	th , 1933	9. Birt	thplace (State or	r Foreign
	e Maryland sa-f show tified at	ctor	Usual Residence of Deceder 10a. State 10b. Co MD Mon		ery		ity, Town or Lo								10d. Inside Cit	•
	h with th	al Dire	10e. Street and Number 8900 Fernwoo	d Ro	ad.			10f. Zip	Code 208	17			_	en of What Co srael	ountry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Divo		Armed F	No ive		Was Deced If Yes, spec		ispanic Orican, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Race - Ame Black, White Specify:		
Maryland 21215-0036	ed within 72 h giene. er than "natu , the Medical	Completed	15. Dec (Specify only the Elementary/Secondary (0-		ducation ade completed) College (dent's Usua kind of wo DO NOT us ysici	rk done d se retired	ation during most)	of worki	ing		of Business/		
/land	ould be file Mental Hy srked oth	To Be (17. Father's Name (First, Mic Abraham Seg	-)					18. Mother		(First, Middle Hana	, Maiden Si (unkr			
	and 2 sho salth and 1.27 is ma er trauma		19a. Informant's Name/Rela Yuri Millo, M	- '	Type. Print)							al Route Numb hesda,		Town, State, 2 20817	Zip Code)	
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Balti	permit. Departm Importa any inju	4 Donation 5 Other (Specify) Yarkon Cemetery May 13,2007 Pethah 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Torchinsky Hebr 254 Carroll St., NW, Washington												orew Fu	meral H	
68760,	Physician / Medical Examiner bulksician and bulksician and street prize the private transit street private transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. Due to	(Amyotr (or as a consended, D (or as a consended)	quence of: yysphag		a1 S	clero	sis				onset and D	eath
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ital Reco	0 8 0	Be Completed	25. Was case referred to me	dical						26 Place	of Death	24a. Was autor performing the Yes	osy ormed? 2 XNo	prior to c death?	topsy findings a o <i>m</i> pletion of car 2 No	vailable use of
Division or Vital Records,	this al din	Certification: To B	3 Suicide 6 □ Co	nding restigation uld not be termined	28a. Date (Mon	of Injury th, Day Year) of injury - At h		M 28	Bc. Injury Work 1 🗆 Y	r: 4 🗆 Nur	sing Hon	ne 5 🛭 Residence 128d. Describe 128f. Location (5	dence 6 E	occurred	cify) ral Route Numb	er,
ā	ospital or hours afte ineral Din y filled in I	al Cert	29a. Certifier 1 🛣 Cert	ifying Ph	vsician: To the	best of my kno	owledge, death	occurred a	at the tim	e, date and	I place, a	City or Tou	vn, State)	nd mannor as	etatod	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29b. Signature and title of	rtifier	and man	asis of examina	ation and/or inv	/estigation,	License	oinion, deat	h occurre	ed at the time,	date and pl	ace, and due signed <i>(Month</i> ay 3, 2	to the cause(s)	
	•		30. Name and address of per Corina Millo	, MD	3289.	Woodbur	n Rd.,	Print)			,	ale, VA	A			
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Registrar DHMH 17 Rev 1/2001

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MAY 0 8 2007

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year May 3, 2007 3:40 P M Sally Kamenshine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2 □ F Director 186-10-0781 99 June 3, 1907 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f shot be notified a Director Maryland 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 E. Jefferson Street, # 440 20852 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🔣 No White þ 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the N once. 10th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Levin Rose Gordon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11320 Dunleith Place, Gaithersburg, Maryland 20878 Robert D. Kamenshine - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Temple Cemetery 5/8/2007 Nashville, Tennessee 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction, In 1091 Rockville Pike, Rockville, Md. Inc. 14. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Unknown Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart FAilure /Medical Due to (or as a consequence of): **Examiner** Hypertension Unknown Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Coronary Artery Disease Unknown physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year ned by the a e detached f 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by cate has been signed page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2【 No 24a. Was an autopsy performed? 1□ Yes **2√**□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation spital or Attendir lours after death. neral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) D0062999 3. 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

3,40 PM

KAMENS'HINF, SPLLY

401, Rockville, Maryland

20852

Rockville Pike,

egistrar's Signature

1119

Petek Donmez

Dr.

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month **EDNA** 05 KEILING 13 07 1408 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗹 F 212-01-9821 89 Director Maryland October 12, 1917 Usual Residence of Decedent 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Allegany Maryland Frostburg 10e. Street and Number 11413 Upper George's Creek Road, S.W 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify Specify: þ 3 Widowed 4 □ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othnany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Winner **Emma Heming** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Dudley 5123 Teaberry Lane Sumer Duck Virginia 22742-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park May 17, 2007 Frostburg Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DISCHSE ACRTIC VALVE 1 YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine that the death certificate be executed -tran Due to (or as a consequence of): burial physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISCASE LOPOMARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen PEGURO - PULCHONARY SECONDARY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy perform-TUMOR certificate LUNG 70 1□ Yes 2: No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, 0 Division or Vital Records, P.

3altimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Af

nas

5

AMEH FAMANA PAZIR State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 80039833

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 07

900 SCTON DRIVE

MD SISOD CLLMBERCAND

Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 07 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO Alisbur If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Director 7/27/1925 <u>235–24–9867</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Director 1 Yes 2 No MD Pocomoke City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 USA within 72 hours after death Funeral 707 Homewood Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Ves 2 No If Yes, Give 1942 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 1945 white Completed the M-dical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Financial @ NASA Manager permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Sapp Fred Knapp 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Homewood Drive, Pocomoke City, MD 21851 Doris Knapp (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 5/7/2007 Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home, Professional Association Mick 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small Cell Carcinoma with Brain Metas **Physician** Jung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of) physician Physician/Medical the attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) a∏i Jnknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 2K) No Medical Certification: To (b) Hospice

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

		performed? death? 1☐ Yes 2☒No 1☐Yes
25. Was case referred to medical examiner?	26. Place of Death (C	heck only one)
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other; 4 ☐ Nursing Home	5 ☐ Residence 6 🗷 Other (Speci
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred

Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 029505 05 - 06 - 2007

Location (Street and Number or Rural Route Number, City or Town, State)

.30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801 BE 050 31. Date filed (Month, Day, Year)

State Registrar

BA 13+1

MAY 0 8 2007

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		For		State of	f Marylan				d Mental H	ygien	e O O O	** }	10	CO
		State Registrar				Cei	rtificate	of Death	O Data of	Reg. N	102 U U	1	10	400
Physicia		Decedent's Name (First, M.			FRANKLI	N	LASHBA	MIGH SR.	2. Date of I Month 05		Ž ^y Ŏ	ear	3. Time <i>a</i> 0545	A M
/Medica Examine	- 2	4a. Facility Name (If not insti	tution, give s	street and nun			4b. City, Tov	n, or Location of E			Ic. County of I	Death	0545	A W
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.		If Under 1 Y	ear If Under 24	Hrs. 8. Date of 1 (Month, 2–23–	Birth Day, Yea			ace (State	or Foreign
Director	-	212-10-6306 Usual Residence of Deceder	11		88	115.			2-23-	1919		IARY:	LAND	
h the Maryland r 28a-f show notified at	_	10a. State 10b. Co	_		10c. Cit	ty, Town or Lo	ocation					10	d. Inside C	ity Limits
he M 28a-f otifie	601		LEGANY		FRO	STBURG		4-		10= 0	Dition of 14ths	1 0-11		
3a or 3	בַּ	10e. Street and Number 100 HONEYSUC	KLE LA	ANE			10f. Zip Co 21532				Citizen of Wha LTED ST			
	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 🏋 Widowed 4 □ Divo	Married	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	2X No re	1	Was Decedent If Yes, specify		? (Specify Yes or Puerto Rican, etc.)	No-	14. Race Black, ! Specify:	White, e	etc.	
2 hou atura	eg	15. Dec	edent's Edu	cation		16a. Dece	dent's Usual O	ccupation		16b.	Kind of Busin	ess/Ind	ustry	
within 7; iene. than "n	Completed	(Specify only h		College (1	-4or 5+)	TIRE	kind of work a DO NOT use n BUILD	one during most of etired) LNG	f working	TII	RE COM	PANY		
ld be filed lental Hyg ked other ic event, i	O	17. Father's Name (<i>First, Mic</i> WILLIAM F. LA		GH					Name (First, Midd SWEEN L		,	-		
nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Rela WESLEY LASHBA		pe. Print) SON		19b. Mailii 1788	ng Address <i>(Si</i> 5 NATIO	reet and Number o	or Rural Route Nur FROST	nber, City BURG	or Town, Sta	te, <i>Zip</i> 1532	Code)	-
ages 1 ar nt of Hea t: If Item 3		20a. Method of Disposition 1 X Burial 2 □ Cremat		emoval from	_ (cemetery, crei	psition (Name of matory or other	rplace)	Date 5-16-20		Location - Cit	-		
artme ortant Injury	-	4 □ Donation 5 □ Oth 21. Signature of Funeral Sea		ee				ddress of Facility			W. MA			
permi Depa Impo any Ir		Man m	Sa	ve B	mo052	S			OME, P.A		OSTBUR			
		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final	e, or compli List only or	ne cause on e	ach line.			-					Approxima Interval Be Onset and	tween
Physician /Medical		disease or condition resulting in death)		Due to (or as a conseq	2851 uence of):	VE HE	AF	PAILUR By DIS	1Z	0	402	W 2	year
Examiner		Sequentiatly list conditions.	l t	/· —			Arry	MATES	By Dis	EM	É (afor	11 - am	year
led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (or as a conseq	quence of):								U
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icate be	cal			1								_		
eath certif attending for use a	Pnysician/Medica	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	T	1 ☐ Live b	come pf pregna pirth 2 ☐ Feta pant at time of cown	al death 3	⊒Ectopic pregr ⊒Other (speci			-	23d. Date o Month		ry Day	Year
res the igne	ል	Part II. Other significant co	nditions cor	ntributing to de	eath but not res	sulting in the u	nderlying caus	e given in Part I.		d tobacco	o use contribu	ute to th		death? Unknown
	Completed								24a. W		24b. We	re autor	sy findings	available
sician: The law certificate has birector, page 2 s	EOS								— ad pe 1□ Yes	topsy erformed? s 2441	dea	ith?	npletion of ∈ 2 No	cause or
cian: sertific	Re	25. Was case referred to me examiner?		Joanital:					Death (Check onl	y one)				
this a	<u></u>	1 ☐ Yes 2 No 27. Manner of Death	ľ	dospital: 28a. Date	•	ER/Outpatier			ng Home 5 □ Re			(Specify	')	
6 6 6	ation	1 Natural 5 □ Po 2 □ Accident in	vestigation		th, Day Year)	Injury	M 250.	Injury at Work? 1 ☐ Yes 2 ☐ No		ie now inj	jury occurred			
al or Atta s after de il Directa d in by ti	Certification:		ould not be etermined	28e. Place buildi	of injury - At hong, etc. (Special	ome, farm, str fy)	reet, factory, of	fice	28f. Location City or	Street a	and Number (ate)	or Rurai	Route Nui	mber,
Hosp 4 hou Fune ely fil	Medical C			ner: On the b					place, and due to t occurred at the tin					(s)
To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of ce	ertifier				29c. Li	cense number		29d. 🗆	Date signed (I	Month, I	Day, Year)	

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

026907

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Jeane Yee May 4, 2007 6:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗷 F Director February 14,1930 578-46-3244 77 Ohio Usual Residence of Decedent with the Maryland a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2K No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 3908 Weller Road 20906 filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event Be Wally C. Yee ဥ Hong Shee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacky Lee - Spouse 3908 Weller Road, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 5/11/2007 Adelphi, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23al Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of) **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause plisease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Multiorgan Failure the burial-trar Due to (or as a consequence of) physician for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4□Pregnant at time of death Day Year 5 Other (specify) ed by the a detached 1 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetic Ketoacidosis 1 Yes 2 No 3 Probably 4 TUnknown page 2 should Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 X No 1□ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident the 1 within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year) 0 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0065069

May 4, 2007

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed To the Hospital or Attending Physician: nours after death.

Ineral Director: After this y filled in by the funeral di within 24 hours a

To the Funeral C

completely filled

10 State

Medical

31. Date filed (Month, Pay, Year) 2007

(Check only one)

29b. Signature and title of certifier



Ani Balmanouluan, Medical Ductor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

May 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician 0509 M RICHARD LEE LANKFORD 05 06 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner PENINSULA KEGIONAL MEDICAL CENTER MICEMILO DALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F Hours Director 220-68-8700 49 11/16/1957 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Somerset Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14547 Jackson Blvd. 21822 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward James Lankford Madeline Dorothy Wimbrow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Edward James Lankford (father) 2405 Lilac Lane, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/9/2007 4 ☐ Donation 5 ☐ Other (Specify) Portersville Cemetery Stockton, MD 21. Signature of Fune Service Licensee 22 Name and Address of Facility Holloway Funeral Home, Professional Association Much 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Immediate Cause (Final disease or condition resulting in death) Shock **Physician** 3 days /Medical Due to (or as a consequence of): Examiner Large Cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or is a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Biloteral Jugular Vein Paronbosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Fx. lune 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an ate has page 2 s autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Propagation 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

00

BA6

Medical

State

Registrar

31. Date filed (Month, Day, Year) MAY 0 8 2007

E

29b. Signature and title of certifier

MARTIN 145 E. Cerroll St., 501:56017 MP 32 Registrar's Signature

N:0.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

030690

29d. Date signed (Month, Day, Year)

May 6 2007

			1 State		epartment of H		ental Hygie	ene	
	*		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of I	Death	Reg	. No. 2 0 0 7	3. Time of Death
398	Physici		Donald Merrick Line				Month	Day Year 5 2007	
3	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	May	5 2007 4c. County of Dear	12:30 P ^M
			Avalon Nursing Home		Нас	erstown		Washingto	on County
24.	Funeral Director		214-28-7449 ★ M 2□ F	e (In yrs. last birthe 88 Yr	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 9 1	9. Bin (Co 918 Ma	hplace (State or Foreign untry) cyland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	Maryl -f sho iled al	tor	Maryland Washington	-	agerstown				1 □Yes 2X No
	or 28a	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
	23a cust b	ral	14014 Marsh Pike		2	1742		U.S.A	A.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Very Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates:		13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ᠘No	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0	72 hc 'natur dical	Completed by	15. Decedent's Education (Specify only highest grade completed)	1 (0	Decedent's Usual Occupa	during most of working	16	b. Kind of Business/	Industry
121	within jene. than "	Idm	Elementary/Secondary (0-12) College (1-4or 5-		ife. DO NOT use retired Bus Drive) -		County Cor	muter
	filed Hygid Sther ent, th	ပိ	8 17. Father's Name (<i>First, Middle, Last</i>)		Dab Brive	18. Mother's Name			inacer
lan	should be nd Mental marked o	To Be	Charles Beachley Line			Cora 1	Melissa (Clark	
Maryland	2 shou and N is ma auma		19a. Informant's Name/Relationship (Type. Print)	19b. N	Mailing Address (Street a	and Number or Rura	l Route Number, C	City or Town, State, 2	ip Code)
	Health tem 27		Diane K. Mitchell (daughter	· — — — —	507 Wellspr				
Baltimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery,	Disposition (Name of crematory or other place	e) ;		c. Location - City or	•
豆	permit. Page Department of Important: If any injury or once.	. 1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Rest no	aven Cemete			agerstown	
Ba	permi Depa Impo any is		Dungle A. Ling			rn Blvd. I	N. Hagers	stown Mary	ral Home land 21742
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not e.	t enter the mode of dying	g, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	(Maconsequence of)	Menny	101			4"
	Examiner		D.	. consequence on	Na Na				TV
	# # #	ner	Sequentially list conditions, if any, leading to humaniate cause. Enter Underlying Cause (Disease or injury	s echiesqueries of):					1/2
	ecuteo and transi	Examiner	that initiated events						
90	icate be executed physician and s the burial-transit	E	Due to (or as a	consequence of):					
68760,		edical	d						
Box	leath certific attending p	In/Me	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome part 12 months? 1 □ Live birth 2		2.DE-ta-it			23d. Date of deli	very
	he deat the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
О.	that the by detact		Part II. Other significant conditions contributing to death but	t not resulting in th	ne underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	w requires been sign should be	ed by					1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
ပ္ပ	law re as bee 2 sho	Completed			_		24a. Was an	24b. Were au	topsy findings available
œ =	Physician: The lav this certificate has al director, page 2.	Som					autopsy performed 1 Yes 2 ☑	#? death?	ompletion of cause of 2 □ No
VII:	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		I out-	26. Place of Death	(Check only one)		
ō	Phys r this ral dir	2	1 ☐ Yes 25CNo Hospital: 1 ☐ Inpatien 27. Manner of Death 28a. Date of Injury			413 Nursing Hom	ne 5 Residenc	e 6 Other (Special	eify)
on	nding Phy ith. :: After thi e funeral (tion	1* ➡•Aatural 5 □ Pending (Month, Day 2 □ Accident investigation		ry Work	? ∕es 2 □ No	od. Describe now	injury occurred	
Division or Vital	or Atter after dea Director in by the	Certification:	2 □ Suicido 6 □ Could not be	y - At home, farm. (Specify)	, street, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Co	29a. Certifier (Check only control of the best of the desired of t	examination and/o	death occurred at the timor investigation, in my op	ne, date and place, a pinion, death occurre	nd due to the caus	e(s) and manner as	stated. to the cause(s)
	o the vithin is or the omple	Mec	one) and manner state 29b. Signature and title of certifier	ed.	29c License	number	004	Data sianad (Marau	B V)
)	F>F0) Greec		01	2327	01	-67-2	007
5	4-6		30. Name and address of person who completed cause of dea	ath (Item 23a) (Ty	pe, Print)	se csta	MD	217+	0
K	Sta			26 Ofar's Signature	T, Ma	7.0100	2 10		
	Registr	ar I	MAY 1 0 2007	~ 1.	South				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PM LYNN DOLAN 2007 MARCUM /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more 8. Date of Birth (Month, Day, Year) 2/12/1933 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 215-28-6885 Director Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 ▼No Director MD. Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Davis Corner Road 21154 United States
14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No
If Yes, Give
Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Maryland '21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Curtis 2 Marcum Ida Pauline Luntsford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Marcum (Wife) 3777 Davis Corner Rd. Street, MD. 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Gardens 5/17/2007 Fallston, Maryland 4 □ Donation 5 □ Other (Specify) Highview Mem. 21. Signature of Funeral Service Life 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home. 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one classe on each inc. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 DEctopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 ☐ Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No page 2 s this certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) habani-31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

2007

			For State	State of	Maryland / Depa			, ,	0000	1 1 C L E	ic
			Registrar	(a. Lant)	Ce	rtificate of	Death	Reg	J. No.	1040	ID
	Physici		1. Decedent's Name (First, Middle Mary And		nnick			Month	Day Yea 16 07	3. Time of Dea 0345	th M
	/Medio Examir		4a. Facility Name (If not institution	CILC		4b. City, Town, o	r Location of Death		4c. County of De		
			WMHS-Braddo	ck Campus		Cumberla	ınd		Allega	any	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	/ear) 9. B	irthplace (State or For Country)	eign
da.	Director		1 8 5 - 1 4 - 6 3 2 0 Usual Residence of Decedent	JA 2	8.5 Yrs.			3-8-19	22	PA	
	land t		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lir	mits
	Mary -f sho fied a	ţ	PA Be	dhord	Ru / /a	Pa Nippe				1 □Yes 2	No
	nr 28a	Director	10e. Street and Number	anona	ban na	lo Mills 10f. Zip Code)	100	g. Citizen of What (Country?	
	th wit 23a c 1st be	al D	4820 Hyndm	an Rd		15534	1		USA		
	r dea	Funeral	11. Marital Status	12. Was Deceder	ent Ever in U.S. 13. es?	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian,	
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Vac Give	⊠ No	1 ☐ Yes 2 🕱 No	Specify:		Specify:		
8	hour tural	ed b		nt's Education		dent's Usual Occup	ation	16	Bb. Kind of Busines	hite	
15	nin 72 n "na Medic	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4	(Give	kind of work done DO NOT use retired	durina most of work	ing	SS. Filling Of Basilios	o madoty	
212	e filed within al Hygiene. I other than ' vent, the Me	mo.	1 2	College (1-4	,	omemaker	1		Own ho	me	
pu	al Hygiv I other vent, ti	Be	17. Father's Name (First, Middle,	Last)		71170111001005		e (First, Middle, Ma	aiden Surname)		
yla	should be find Mental I marked of	은	Ray Roscoe					he E. R			
Maryland 21215-0036			19a. Informant's Name/Relations	, , , ,			and Number or Rur				
	1 and 2 Health a tem 27 is		Mary M. Minn 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	ick/ Daug	hter PO 1	Box 222	Hyndman	PA 15	5 4 5	or Tourn State	
Baltimore,			1 Burial 2 Cremation	3 ⚠ Removal from St	ate cemetery, cre	matory or other plac	ce)	20	oc. Location - Oily (or rown, state	
Ħ	# E E E =		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service	-	Hyndman	Cometer 2. Name and Addre	s of Facility	9-2007	Hyndman	, PA r Funera	
Ba	Depa Impo any il		MINIMA	W Alexan	14.	2100 0 1 6 0	COCHOI	22 C+	Il dies er	r Funera. _ PA 155.	15
į.	* 7 %		23a. Part1. Enter the disease, or shock or heart failure. List	complications that cau	ised the death. Do not en	ter the mode of dyir	Claren ng, such as cardiac	or respiratory arres	nynaman t,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		numity A	gimse	of Price	m mañ c	i i	Onset and Death	
d	/Medical		resulting in death)		as a consequence of):	1	-1 1.55	V-(0 V-(-	1	3 000	<u>.7</u>
	Examiner		Sequentially list conditions,	b							
	pe tis	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur	as a consequence of).						
	xecut and il-tran	Examine	that initiated events resulting in death) Last	c	as a consequence of):						
8760,	cate be executed physician and the burial-transit	dical E									
687	cate ohy:	edic		a							
Вох	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		75-4			23d. Date of d	elivery	
	ne death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 █ No		nt at time of death 5	⊒Ectopic pregnancy ∃ Other <i>(specify)</i>			Month	Day Year	
P.0	⇒ > ≥	hys	9 ☐ Unknown								-
	es ign		Part II. Other significant condition	Sal Fish	th but not resulting in the u	nderlying cause giv	en in Part I.			to the cause of death	
Ö	w requir been s should	sted	0113 00112 17 13	10	11691001	·		1 ☐ Yes	2)(No 3 □ I	Probably 4 □Unkno	
Records,	e las has le 2	Completed by						24a. Was an autopsy	prior to	autopsy findings availa completion of cause	able of
al	Th page		05.14						ed? death? SNo 1 ☐ Ye		
Vital	Physician: this certific ral director,	Be C	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hospital:	entions OFFRIOUS	nt 3 DOA Oth	or:	(Check only one)			
ō		.T	27. Manner of Death	28a. Date of	Injury 28b. Time o	" 0 DOX	4 Li Nursing Ho	me 5 L Resident 28d. Describe how	ce 6 Other (Sp	pecify)	
<u>o</u>	Attending I r death. ector: After by the funer	tior	Natural 5 Pendin 2 Accident investig	19	Day Year) Injury		k? Yes 2 □ No		. ,		
Division or	l or Attendatter death Director:	iffice	3 Suicide 6 Could i 4 Homicide determ	singal Zoe, Flace UI	injury - At home, farm, str , etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F	Rural Route Number,	
Ö	tal or / rs after al Dire	Certification:	A Lond	Bananig	, etc. (opeony)			Oily or Town,	Diale/	_	
	the Hospital nin 24 hours a the Funeral I npletely filled	edical	(Check only 2 Medical	Examiner: On the basi	est of my knowledge, deat is of examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the cau	se(s) and manner a	as stated. ue to the cause(s)	
		Medi	one) 29b. Signature and Ne of certifie	and manne	r stated.	29c License	e number	294	Date signed (Mo)	oth Day Voorl	
	o Viiti	5	255. Signature and the or certifie	mot	m.D	AG	3118	290		2 AA	
	6		30. Name and address of person	who completed cause	of death (Item 23a) (Type	Print)	- 110		7-10-	7	
	mas		WIRASAT H	HASNAN	200 Setor	, Drive	31/8 Cumbe	Mand	mD:	2002	
	Sta		31. Date filed (Month, Day, Year)	-	istrar's Signature					<u> </u>	
	Registr	ar	MAY 18	2007	10 B. B.	action of					

			1 - For Stata Registrar	State of M	aryland		artmen rtificate			and Mo		giene Reg. No.	7	15457
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, L JOSEPHINE FLI 4a. Facility Name (If not institution, g	ZABETH MO	OSER		4b, City,	Town, or	Location of		2. Date of Dea Month	Day Day 4c. County of	Year 7	3. Time of Death
	Funeral	lei	JULIA MANOR HEA	LTH CARE C		t birthday)	If Under	HA 1 Year	GERS'	TOWN	8. Date of Birt	WAS	HING	TON lace (State or Foreign
	Director		220-18-0192 Usual Residence of Decedent	1□M 2 X F	91	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day MARCH	15,1916	Cour	RYLAND
	e Marylan Ba-f show	Director	10a. State 10b. County MARYLAND WASHI	NGTON	10c. City,	Town or Lo	cation HAGE	RSTO	WN				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th		10e. Street and Number 12814 POINT SALE	M ROAD			10f. Zip		740			10g. Citizen of W	hat Cour $\mathrm{S.A.}$	ntry?
980	4 within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-f show the Medical Exacting court be profithed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 Tyes 2		spanic Ori , Mexican Specify:	gin? (Spec i, Puerto P	cify Yes or No- lican, etc.)		- Americ , White,	ean I <i>n</i> dian, etc. IITE
21215-0036	d within 72 jiene. r than "na ine Medic	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or		(Give	dent's Usua kind of wor DO NOT us ASSE	k done di	uring mosi	t of workin	g	16b. Kind of Bus		dustry NUFACTURE
Maryland 2	uld be filed fental Hygi rked othar tic avent, I	To Be C	17. Father's Name (First, Middle, Las CHARLES E. MORG				4 4 5 6 5 4				(First, Middle,	Maiden Sumame		210111010111
Mary	s 1 and 2 should f Health and Men itam 27 Is marke other traumatic:		19a. Informant's Name/Relationship RALPH I. MOSER/S		- 17							r, City or Town, S		Code) AND 21740
Baltimore,	Pages 1 annent of Healurt: If itam 2		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Denation 5 □ Other Dec	☐Removal from State	20b. Plac	e of Dispo	sition (Nam natory or of	e of her place)	Da	ite	20c. Location - 0	City or To	own, State
Baltii	permit. Pages Department of Important: If i any injury or once.		21. Signature of meral Service L	ensee	M. Dea	22	O CEMI L. Name and AST FU	d Address	of Facilit	ME. '	7606 01	BOONSBOR d Nation ro, Mary	al l	Pike
SALES SERVICES	rnysician /Medical Examiner	16	23a. Flant 1. Enter the diseless of corshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	y one cause on each li	ne.	uuu nce of):	er the mode				respiratory ar	rest,		Approximate Interval Between Onset and Death Grant Street
8760,	cate be executed obysician and the burial-transit	icai Examine	Sequentially list conditions, if any, leading to immediate must be found to the following Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as										
P.O. Box 68	the death certific y the attending p iched for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pre					23d. Date Mont		ery Day Year
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of Vit	hysiciar his certil il directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie		VOutpatien	-	A Other	4 X Nu		<i>(Check only or</i> e 5 ☐ Resid	ne) ence 6 ∏Othei	(Specify	1)
ion	Attanding Physician: r death. actor: After this certific, by the funeral director.	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate		ry y Year) 28	Bb. Time of Injury	M 28	Bc. Injury Work?	at ? es 2 □ h		3d. Describe h	ow injury occurre	d	
Divis	al or Attanos after death	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			e, farm, stre	eet, factory,	office		28	Bf. Location (S City or Town	treet and Number n, State)	or Rura	l Route Number,
	To the Hospital or Attanding Physician: within 24 hours after deals To the Funaral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifying P (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best iminer: On the basis o and manner st	f examination	dge, death and/or inv	occurred a restigation,	it the time in my opi	nion, deat	d place, ar th occurred	nd due to the c d at the time, d	ause(s) and man late and place, ar	ner as st	ated. the cause(s)
:	To the within 2 To tha complet	W	29b. Signature and title of certifier	gru	ey		29c.	License	number 28	365	2	29d. Date signed 5- 11	(Month, i	Day, Year)
0	5H-3		30. Name and address of person who	completed cause of d	121	3a) (Type,	Print) ·	le 8	trau	1- H	eigsto	5- 11	0 2	21740
2	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Pagistr	ar's Signature	Sp	uls			•				

07-036	33	
Donald	Н.	Morse

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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oriala i i. Worok		1- For State Registrar		ficate of De		u Mentai Hy		. No.	7 1080		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Donald Harry Morse					2. Date of Death Month May 13, 20	Day Year	3. Time of Death 0609 hrs		
		4a. Facility Name (if not institution, give street and number)				Location of Death	Way 10, 20	4c. County of Death			
Funeral		45493 Hour Road Holly Road 5. Social Security Number 6. Sex 7. Agr	e (In yrs. last		kington F		8. Date of Birth	St. Mary's (MM/DD/YYYY) 9. Birt	hplace (State or		
Director		217-66-2469 1X _M 2F	52	Yrs. Mo	nths Day			1 105/ Foreig	nMaryland untry)		
. any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location West									
Maryiand 28a-f show	tor	Virginia Hampshire				Rio			1 Yes 2 X No		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at ance	Il Director	10e. Street and Number Rt. 29 South				6755		. Citizen of What Cour			
r death w or items must be	Funeral			If Yes, sp	ecify Cubar	spanic Origin? (Spen n, Mexican, Puerto R		White, etc.	can Indian, Black,		
urs afte tural",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com	npleted) 1	6a. Decedent's Usi	2 X No	tion (Give kind of wo	ork done	Specify: 16b. Kind of Business/I			
036 thin 72 ho ne. r than "na ledical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5			most of working life. DO NOT use retired all Installer		d)	Construc			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Henry James Morse	,			18.Mother's Name (I		aiden Surname) ablonicky			
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	2	19a. Informant's Name/Relationship (Type, Print) Charlotte Ann Morse / Mother	. ()			et and Number or Ru Lexington		er, City or Town, State 20653	, Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	ate cre	ace of Disposition (I ematory or other pla opolitan Cr	remator	у Мау	18, 2007	20c. Location - City or Alexandria, V			
Bal permit Depar Impor	ļ	21. Signifure of Funeral Service Licensee	(new)	7 P.O.	Box 2	s of Facility -Gardiner Ft 70 Leonardt	town, MD	20650			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	_				respiratory arres	t, shock, or heart	Approximate Interval Between Onset and		
caminer		Immediate Cause (Final disease or condition resulting in death) a. Atheroscler Due to (or as a conse		ardiovascul	ar dise	ease			Death		
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):				-				
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated									
cuted and transit	EX	d	rquance or).								
760, icate be executed physician and the burial - transit	Medical			erME, g867,	5.22.07	7 TT					
5876 ertificate fing phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcon 1 Live birth		2 Fetal dea	ath 3	Ectopic pregnanc	су	23d. Date of delivery Month) Day Year		
D.O. Box 687 that the death certific ned by the attending a detached for use as the	ysician/	1 Yes 2 No 9 Unknown g Unknown	time of death	h 5 Other (S	Specify)						
P.O. Es that the gned by the detached	by Phy		contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?			
ords, P.C w requires that is been signed is should be deta	ted t	Chronic alcoholism					1 Yes	2 No 3 Prob	topsy findings available		
e law re e has be	Completed	-					autopsy perform	prior to oned? death?	ompletion of cause of		
Vital Rec ysician: The l his certificate l director, page	a l	25. Was case referred to medical			26.Place	of Death (Check on	1 Yes 2	No 1 ✓ Ye	s 2 No		
F Vita	P B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie		R/Outpatient 3			· · · · · · · · · · · · · · · · · · ·	esidence 6 🗸 Other	: Scene		
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	ry 2 ear) 2	8b. Time of Injury		ry at Work? 2 Yes 2 No	8d. Describe ho	w injury occurred			
Division pital or Attenc ours after death teral Director:	Certification:		jury - At hom	e, farm, street, fact	ory, office b	uilding, etc. 2	8f. Location (Sta or Town, Sta		ral Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier 1 Certifying Physician: To the best of my one) Medical Examiner:On the basis of exam				· ·					
F 2 5 8	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor	nth, Day, Year)		
		(aufakell)			O.C.	M.E.		May 14, 2007			
T		 Name and address of person who completed cause of during Laron Locke MD. Assistant Medical Example. 			et, Baltir	nore, MD 2120	1				
St Regist		31. Date filed (Month, Day, Year) MAY 1 6 2007	's Signature	d .							
		A CAN CONTRACT AND	ATTENDED TO STATE OF	(A)							

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31. Date filed (Month, Day, Year)

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Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician John B. Moloney May 5,2007 9:05pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director 83 012-24-0037 Jan 18,1924 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1y⊟Yes 2 No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6814 Greyswood Rd 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 3 ☐ Married 1946 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Viral Oncologist Medical Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin J. Moloney Florence A. Becker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia W. Moloney/Wife 6814 Greyswood Rd, Bethesda.MD 20817 Department of Health Important: If item 27 any Injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery May 9,2007 Washington DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) egpiratom **Physician** /Medical Due to (or s a consequence of): Examiner vagestice Hea if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ✓ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1□ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Aatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral D 29a, Certifier 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and the of gertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi, M.D. Old Georgetown Rd, Bethesda, MD 20814 31. Date filed (Month, Day, Year) Registrar's Signature State 0 8 2007 MAY

Registrar

Baltimore, Maryland 21215-0036

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Division or Vital

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or iteme 23e or 28e-f show ery injury or other treumatic event, the Mudical Examinar must be multipled at once.
1	Physician /Medical Examiner
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral Director

an	1. [Registrar Decedent's Name (First, Mic	ddle, Las	it)			ertificate d	Deali		2. Date of Dea Month	ith Day	Yeer	3. Time of	Death
al		Eleanor Jea		orris						May		2007	9:29	A۱
er	4a.	Fecility Name (If not institut	tion, give	street and nu	mber)		4b. City, Town	n, or Location of	of Death		4c. Cou	unty of Death		
		Garrett Coun Social Security Number	ty M			ital rs. last birthda	Oakla v) If Under 1 Ye		24 Hrs.	8. Date of Birtl		rett	place (State or	r Fornic
	5. 3	172-16-3832		_ M 2[X F	85	Yrs.	Months Da		Min.	June 20	r, Year)	Cou	ntry) nsylvan	
		ual Residence of Decedent			100	City Town or	Lagation						10d Incide Cit	h e è lomit
Ä	108	a. State 10b. Cour	•			City, Town or	Location						10d. Inside Cit 1 ☐ Yes	
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5		3 X Widowed 4 □ Divorc	ed	If Yes, Gr Year or D	oates:		1 ☐ Yes 2 🔀 f	No Specify:			Spe	ec <i>ify:</i> Wh:	ite	
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o Be		Bruce L. Kre	_							odbeck		,		
ř		a. Informant's Name/Relation		Type, Print)		19b. Ma	iling Address (Stre	1			r, City or To	wn, State, Zi	p Code)	
		Wendy Wakefi	eld.	Daught	er		0 Alexan							
	-	a. Method of Disposition			20b	. Place of Dis	position (Name of rematory or other)	1		ate		on - City or T	own, State	
		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other					and Crem		5/12/	07	Cumbe	rland	MD	
	21	. Signature of Funeral Servi	ice Licen	See			22. Name and Ad	dress of Facilit	ty					
		Katheren		Jucita	ir		David A	Second :	Stree	t. Oak	land.	P.A. MD 21	550	
	23	3a. Part1. Enter the disease, shock, or heart failure. L	, or comp	olications that	mused the de	eath. Do not e	enter the mode of	dying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Bety	e veen
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07-03717 Daniel J. Owen

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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el J. Owen		1-For State Crivial yields Certificate of Death	Reg. N	0	
Physicia		1 Decedent's Name (First, Middle,Last)	ate of Death Nonth Day	/ Year	3. Time of Death 0225 hrs
xamii	ner	DANTED	ay 15, 2007	4c. County of Death	
		Chestertown Chestertown		Kent	
		7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8.1		M/DD/YYYY) 9. Birth	nplace (State or
Funeral Director		213-31-9798 Table 1 20 Trick Months Days Hours Min. 1	Feb 25	1987 cou	n _{intry)} Delaware
		Usual Residence of Decedent			10d. Inside City Limits
* any		10a. State 10b. County 10c. City, Town or Location Kent Galena			1 Yes 2 XNo
rland -f shoronce.	tor	MD Kent Galena 106. Street and Number 107. Zip Code	10g.	Citizen of What Cour	itry?
ith the Maryland 23a or 28a-f show	Director	14080 Gregg Neck Rd. 21635		U.S.A.	
vith th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify	fy Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
r death wi or items must be	Funeral	1 XNever Married 2 Married 1 Yes 2 X No		Specify: Wh	ite
after (by F	or Dates:		b. Kind of Business/	Industry
hours "natu	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind or work during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+))	Roofing	
36 thin 72 than than	ompleted	10 Roofing Laborer 18.Mother's Name (Fire	Last Middle Mai		
5-0036 led within 7 Hygiene. I other than	ပ္ပ	Melissa	Turnb	ull	
2121 ould be fi Mental I marked	Be C	Roland Owen, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Numbe	r, City or Town, State	e, Zip Code)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Tiem 27 is marked other than "natural", or items 23a or 28a-f she remunatic event, the Medical Examiner must be notified at once remunatic event,	2	Roland Owen, Sr. (father) 14080 Gregg Neck Ro	d. Gar	Oc. Location - City or	Z Town State
- put m m		Zop. Place of Disposition (Name of Contests)		Galena,	
Pages Inent of I		In the Depth of Community	9/0/		
Baltimore, permit. Pages I a Department of He Important: If it injury or other I		21. Signature of Furieral Service tricenses M00510 B1b1e Baptist Cent.	ome oi t. Gal	ena, MD.	21635
	_	Day Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	espiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
<i>r</i> sician Jedica		failure. List only one cause on each line. Immediate Cause (Final disease a. Sharp Force Injuries			Death
Examine	r	or condition resulting in death) Due to (or as a consequence of):			
	<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	F2 LV		
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687 certific	ise as	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify)			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and	1010	2 3b. Was decedent pregnant in the past 12 months? 1	23e. Did tob	pacco use contribute	to the cause of death?
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ital sician: s certi			-		her:
of Vital Records, ing Physician: The law require After this certificate has been signed.	<u>ਦ</u>	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h Subject cut a	low injury occurred and stabbed sel	f
ion tendir cath.	the fu	Natural 5 Pending Investigation 2 Accident Accident Polynomial Pol	28f Location (S	Street and Number or	Rural Route Number, City
Division tal or Attendir as after death.	d in by	28e. Place of injuly - At home, takin, or out, the same	T C	^{tate)} Grove Road, Kenr	
ie o			due to the caus	e(s) and manner as s	stated.
the H	completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occorred at	t the time, date	and place, and due to	
T. wit	COI			29d. Date signed (wonur, Day, rear)
		auetz o.c.m.E.		1, 10, 200	
2		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	1		
<i>A</i>		31 Date filed (Month, Day, Year) 32 Registrar's Signature			
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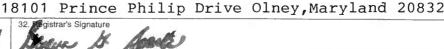
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/AVFND#10a,b,ccerFH5/8/07,BWW,Mccb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month May 1938 Felix Bautista Orozco 5,2007 Pedro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 8. Date of Birth (Month, Day, Year) Feb. 22, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**⊠** M 2□ F none 74 Guatemala Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Director 1 Twee 2 □ No Guatemala City, Guatemala Guatemala NONE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or must be 01019 Caminero Blvd 12-58 Zone 6 Guatemala 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. "natural", or item edical Examiner r 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 X Yes 2 □ No s Specify: Guatemalan ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Josefina Orozco Pablo Bautista Soto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3209 Hitchcock Court Olney, Maryland 20832 S Pages 1 and 2 street of Health a Julio Alvarado/Son-in-law 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Guatemala City, Date Cemetary crematory or the rolace Cemeterio Jardin Hermano Pedro 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any Injury or once. 5/16/2007 5 ☐ Other (Specify 4 □ Donation Guatemala 21. Signature of Funeral Service Liger PHILIPADS RIMALDI FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MINUSES disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner EROSCLEROTIC COROMARY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Ischemic CARDIO MYORATHY law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of deliver 3 □ Ectopic pregnancy for in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Day Month Year 5 ☐ Other (specify) 1 Yes 2 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has autopsy performed? page 2 The certificate 1□ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred Affer 1. Natural (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 1 Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I Hospitai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

R.Larkin MD 31. Date filed (Month, Year 08 2007

29b. Signature and title of certifies



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

may 05, 2007

			1- State of Waryland / Department of Healt Certificate of Dea		Reg. No.	10404
	Physici	an	1. Decedent's Name (First, Middle, Last) Ethel Rae Paine	2. Date of D	Day Vear	3. Time of Death 6:50P. M
-Ve	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local	May ation of Death	6, 2007 4c. County of De	
4		H	Laurel Regional Hospital Laurel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un	Inder 24 Hrs. 8. Date of E		ce George's
day	Funeral Director		187-14-5368 1□ M 2X F 85 Yrs. Months Days Hot		0,1921 Per	rthplace (State or Foreign Country) Insylvania
	yland ow at		Usual Residence of Decedent 10a. State			10d. Inside City Limits
	e Mar 8a-f sh otified	ctor	Maryland Prince George's Adelphi			1 □Yes 2X No
	ath with the 23a or 2	ral Dire	10e. Street and Number 2934 Powder Mill Road 20783		10g. Citizen of What C United St	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispania If Yes, specify Cuban, Me. 14. Was Decedent of Hispania If Yes, specify Cuban, Me. 15. Was Decedent of Hispania If Yes, specify Cuban, Me. 16. Yes, Sive Year or Dates:	ic Origin? (Specify Yes or N exican, Puerto Rican, etc.) ecify:		
15-(in 72 h "natu ledical	olete	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Business	s/Industry
212	ed with ygiene. er thar t, the N	Som	Elementary/Secondary(20-12) College (1-4or 5+) Cafeteria Worker	r	High Point	High School
/land	uld be fill Mental H Irked oth tic even	To Be	70 7 7	Mother's Name <i>(First, Middl</i> D ra		Clites
, Mar	and 2 sho raith and I 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Carol Adolphsen -daughter 19b. Mailing Address (Street and National N	lumber or Rural Route Num adows Drive S	ber, City or Town, State, Sykesville,	^{Zip Code)} Maryland2178
Baltimore, Maryland 21215-0036	t. Pages 1 artment of He rtant: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemeter		Brentwood,	Maryland
Ba	Depa Impo any I		21. Signature of Funeral Service Licensee 22. Name and Address of F Donald V. Bor 4400 Powder M	rgWardt Funer Mill Road Bel	al Home, PA	rvland 20705
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe Chronic Obstructive Followers of the condition of the c	ch as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hypoxia Due to (or as a consequence of):			
P.O. Box	at the death certi by the attending tached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		23d. Date of de Month	livery Day Year
rds, F	w requires that been signed be should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa		tobacco use contribute to Yes 2 ☐ No 3 ☐ P	
ĭ	The ate h	Completed	25. Was case referred to medical		opsy prior to ormed? death? 2 XNo 1 ☐ Yes	utopsy findings available completion of cause of 2
	Physiclan: this certificanal director, programs	To Be	examiner?	Place of Death (Check only ☐ Nursing Home 5 ☐ Res		noify)
_	ng fte		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2	28d. Describe	how injury occurred	Olly
DIVISION	al or Atte s after dec il Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	(Street and Number or Ri wn, State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, and due to the , death occurred at the time	cause(s) and manner as , date and place, and due	s stated. e to the cause(s)
	Verificial verifical verificial verifical verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial verificial ve	Σ	29b. Signature and little of certifier 29c. License numb D64874	per	May 6, 200	h, Day, Year) 7
	•	ļ	38 Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahab Bavani, M.D. 10724 Little Patuxent Parkway	, #200 Colum	bia. Marula	nd 210//
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 8 2007 Segistrar's Signature	, "233 3010iii	-10; Holy 10	21077

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** \mathbf{P}^{M} 2007 2:30 May 2, Peomroy Mary Louise /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Rocky Ridge 13812 Motter Station Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 □ M 2 🕱 F Director 24, 1922 Maryland 85 April | 214-28-1051 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Maryland Rocky Ridge Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21778 United States 13812 Motter Station Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if them 27 is marked other them any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Seamstress 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Parrish Lauree Repp Raymond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13812 Motter Station Rd. / Rocky Ridge, MD 21778 Robert L. Peomroy / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mount Tabor UCC Cem 05/07/2007 Rocky Ridge, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 104 E. Main St. / Thurmont, Maryland 21788 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2571 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Tes Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 🔯 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide thin 24 hours a the Funeral C The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Carroll, MD / 310 S . Seton Ave. / Emmitsburg, Maryland istrar's Signature State 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] []] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 07 2045 William Weston Pusey, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAGIONA Nicom 10 Salisburg PONINSULA Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 82 Director 577-46-2459 April 17,1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** MD Worcester Snow Hill death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 W. Federal Street 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ②No If Yes, Give Year or Dates: or items. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 Specify: Completed by 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 12 <u> Agricultural Entrepreneur</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Weston Pusey Annie <u>Florence</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If Item 27 any injury or other tr Daniel Pusey- Son 5222 Creek Road Snow Hill, MD 21863 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christian Church Cem. 5/7/2007 Snow Hill, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E Main Street Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial min utes /Medical Due to (or as a consequence of): **Examiner** Coronaly artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 42913 Due to (or as a consequer ce of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician; after death.

Director: After this certific
In by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific mo D41721 05 03 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MAY 0 7 2007

PAVLOS

MD

STEPHAN

31. Date filed (Month, Day, Year)



400

E. SHORE DR.

SALISBURY

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MAG LARRY GLADDING PHILLIPS 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MED. CTR WICOMICO SALISBURY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2 □ F 227-62-9846 60 VIRĞINIA Director APR 28,1947 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director VA ACCOMACK PARKSLEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21266 MAPLE VILLAGE DR. 23421 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE 12 POULTRY PLANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLIFFORD C. PHILLIPS 2 VELMA ANNIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY LOU McCONNELL (SISTER) 28001 MAIN STREET HALLWOOD, VA 23359 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parksley Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/12/2007 Parksley, VA 21. Signatur uneral Service Li 22. Name and Address of Facility THORNTON FUNERAL HOME, U. THORNTON 24183 CHADBOURNE -PARKSLEY, 23421 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MICCARDIAL INFACTION ACUTE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, frame dealing to him delicate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trail Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: JSe i 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of α page death? 1 ☐ Yes 2 ☐ No performe 1∐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Hipatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 1 Natural 5 ☐ Pending investigation 1 Yes 2 No ours after death.

reral Director: / 2 Accident the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar

MAY 1 0 2007

Treath

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MILFORD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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0	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 🕽	Removal from S	tate	metery, crer	natory or o	ther plac					cation - City		
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Ba	permit. Page Department important: if any injury o		21. Signature of Funeral Service Lice	Stote	temes	Da 11	nzans .70 Rc	ky-(Soldbe Llle I	erg M Pike,	lemoria Rockv	1 Cha ille	apels Mar	, In ylar	nc. nd 20852
5.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	used the death.	Do not e	er the mod	e of dyin-	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition	-a. V	Enlyi	Corta	N	as	141	m	las			1	Oliset and Death
- 8	/Medical Examiner		resulting in death)	Due to (o	or as a conso u	ence of):	1	+1	1950		iers				
		_	Sequentially list conditions,	b. Jue to (o	or as a conseque	ence of):	10	h	XVE	VC				+	
	ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,, ao a concede	01100 017.								1	
	execu n and al-tra	xar	that initiated events resulting in death) Last	Due to (o	or as a conseque	ence of):									
8760,	ate be executed hysicien and the burial-transit	dicai [d											
9	40 E E	edic		_ v											
Вох	the death certific y the attending p ached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnan		∃Ectopic pr	0000000				2	3d. Date of	t delive	•
O. B	deat	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		int at time of de		Other (sp						Month	ı	Day Year
<u>о</u>	at the de	Phy	9 🗆 Unknown									_			
	requires that een signed b nould be deta	ρ	Part II. Other significant conditions	contributing to dea	ath but not resul	Iting in the u	nderlying c	ause give	en in Part I.				_		e cause of death?
Vital Records,	w requir been s should	eted	- do Vente	0	cre	the	1				10	Yes 2	100 3		ably 4 Munknown
ec	6 S C1	Completed									24a. Was	psy	prior	r to com	sy findings available apletion of cause of
E E	Th ete pag										1 ☐ Yes	2A No	deat	Yes :	2 ⊠ No
⋚	Physicien: T this certificet al director, pa	Be	25. Was case referred to medical examiner?	Hospital:				Oth	25		(Check only o				
ð	Phys rahdi	- T	1 Yes 2 No 27. Manner of Death	1 ☐ In		ER/Outpatier 28b. Time o		/A	4 Mu		ne 5 Resi 28d. Describe			Specify)
Division	ding h	tion	1 Natural 5 Pending 2 Accident investigation	(Month	n, Day Year)	Injury	м -	8c Injun Worl	k? Yes 2∐I				00001700		
<u>isi</u>	or Attendate death Director: A	fica	3 ☐ Suicide 6 ☐ Could not I	28e. Place	of Injury - At hor		reet, factory	r, office		- 1	28f. Location (Street and	d Number o	or Rural	Route Number,
Ö	s after s after st Direct	Certification:	4 Homicide determined		g, etc. (Specify,		,				City or To	wn, State)			
	To the Hospitei or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical ((Check only 2 Medical Exa	hymician: To the l miner: On the ba	sis of examinati	vledga, daal ion and/or in	li occurred vestigation,	at the tin	ne data an	d place a	trid due to the ed at the time,	czuse(s) date and	und mala e place, and	res sta	the cause(s)
	within 2 To the complet	Med	29b. Signature and title of certifier	and mann	er stated.		200	. Licens	number			29d. Date	signed (A	Aonth [Day, Year)
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r	12		20 Name and address of a super	Completed	of death (harri	220) /T	Drive)	700	1	75.	ر د	-/	3/ 6		
			30. Name and address of person	A P A	C 7	Zoa) (Type,	76	(an	Te	By.	Rock	=vil	10 N	10	20856
	St	ate	31. Date filed (Month, Day, Year)	32	gistrar's Signat	ure	1000		- 4						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene (10.00)

			For State Registrar	State of Ma	iryianu /		tificate of		vieniai my	Reg. No	6001	164/0	
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of Do	eath Da 13	3 2007	3. Time of Death	
e d	/Medic		EMILY AMY 4a. Facility Name (If not institution, given	RUSSELL			4h City Town o	or Location of Deat	MAY		C. County of Deatl	22:30 M	
I.	Examin	er	MEMORIAL HOSPITA				CUMBER				ALLEGANY		
	Funeral Director		5. Social Security Number 6. 9 218–12–5076		e (In yrs. last b 83	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year	Co.	nplace (State or Foreign untry) vland	
Ī	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits	
	Maryli f sho	tor	MD Allega	ny			rland					1 X Yes 2 No	
	h the	Director	10e. Street and Number			-	10f. Zip Code			10g. C	itizen of What Co	untry?	
	ath wii	ral	315 Franklin					502	j		USA		
030	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cub 1 ☐ Yes 2🌠 No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or Note of Rican, etc.)	0-	14. Race - Amer Black, White Specify:		
212-0036	72 ho 'natur dical l	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	a. Dece	dent's Usual Occup kind of work done	oation during most of wor d)	rking	16b. l	Kind of Business/I		
7	within sne. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)						77	,	
D	illed Hygi ther nt, t	Be Co	17. Father's Name (First, Middle, Last	")	l		urgery i	echniciar 18. Mother's Nar		e, Maide	<u>Hospit</u> n Surname)	al	
/land	ould be Mental arked o	To B	Emil	Peter	Kai	mauf		Millice	ent	Lou	ise	Cooper	
Mar	permit. Pages 1 and 2 should be i Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve once.	·	19a. Informant's Name/Relationship		1		-	and Number or Ru				· ′	
	1 and Health em 27		Raymond N. Russel 20a. Method of Disposition	1 / Husban			rranklin sition (Name of natory or other pla	Street,	Date		ocation - City or	002 Town State	
Ö E	Pages ent of nt: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1			ce) Cem: 05/	17/2007		,	,	
saltimore,	rmit. F partm portar y inju		21. Signature of Funer I Service Lice	nsee	p••••							Home, P.A.	
מ	P E E E		Kakut	a. Cicle	ne			ır Street			nd, MD 2	21502	
	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Respira	atory F	ail		ng, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death 12 Hours	
	Examiner		Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease										
		ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a			IVE I QIM	mary Dis	ease			10 Years	
	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a		n of):							
Ď,	be exician	al E		Due to (or as a	a consequence	3 01).							
08/00	= 0° @	ledical		_d								-	
O. BOX	w requires that the death cert been signed by the attendin should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у			23d. Date of deli Month	very Day Year	
νς. Γ	s that ned by e deta	by Ph	Part II. Other significant conditions	-	-				23e. Did	tobacco	use contribute to	the cause of death?	
ora;	equire en sig ould b	ed b	Colon Ca	ancer, Pneu	ımonia,	Rig	cht Colle	ctomy	1)∑	Yes 2	2□No 3□Pre	obably 4 □Unknown	
II Records	The la ate has page 2	Completed				· · · ·			24a. Was auto perf 1□ Yes		prior to death?	topsy findings available completion of cause of	
VItal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Lou	26. Place of Dea					
0	Physer this eral di	1: To	1 ☐ Yes 2M No 27. Manner of Death	28a. Date of Injul	y 28b	. Time of	28c. Inju	ry at	łome 5 ☐ Res 28d. Describe		6 □Other (Spec	cify)	
IVISION OF	ath. rr: Afte	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(<i>Month, Da</i> y n	Year)	Injury	Wo	rk? Yes 2 □ No					
	ai or Atters af Directors of in by the	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ry - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location City or To	Street a	and Number or Ru te)	ral Route Number,	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification:	29a, Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination a	ge, deat and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time	e cause(: , date ar	s) and manner as nd place, and due	stated. to the cause(s)	
	To the To the Comp	×	29b. Signature and title of certifier	1.01.			29c. Licens			29d. Da	ate signed (Month	n, Day, Year)	
	3		imoun		ne,	_		3158		MAY	z /S ,200	07	
	nes		30. Name and address of person who Michael Stask	o, M.D., 9)24 Set			mberland	, Maryla	and	21502		
Ŷ	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 1 6	. 10	ar's Signature	8 1	Brack s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year 2007 REINHARD ROTHAUGE MAY 8 2:40 A 0. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Yea Nov. 18, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Year! Hours 1 X M 2 □ F 77 1929 Germany 220-41-0149 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 X Yes 2 No Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Germany 1479 Dockside Court 21701 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military Officer German Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Rothauge Mattilde Herbold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1479 Dockside Court Frederick, Maryland 21701 Berna Rothauge / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State May 9, 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 701 disease or condition resulting in death) Due to (or as a neequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): dy 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes

Physician /Medical Examiner

attending physician

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be ပ

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

"natural", or i

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any Injury or other traumatic event, <u>it</u>

Baltimore, Maryland 21215-0036

Examiner Completed Be 2 Certification:

the Hospital or Attending Physician: The law requires that the death certificate be executed

After this

after death in by the

within 24 hours a To the Funeral I

Division or Vital Records, P.O. Box 68760,

Physician/Medical IF FEMALE: 23b. Was decedent pregnant ☐Yes 2☐No 9 ☐ Unknown 2

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed' 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No

1 Inpatient 28a. Date of Injury

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3□ Suicide

4 Homicide

(Check only one)

29a. Certifier

5 Pending investigation 6 Could not be determined

(Month, Day Year)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month Pay Yea)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

146 81701 501

State Registrar

Medical

14006 strar's Signature

			For State Registrar	State of M	aryland		artment o rtificate			and N	/lental Hy	/gier Reg. i	20	17	1647	
	Physici /Medic	-	Decedent's Name (First, Middle, La	Mary Lo	uise S	Showe					2. Date of D Month May 1	[Day 2007	Year	3. Time of Death 2:45 A	
	Examin		4a. Facility Name (If not institution, gi)		4b. City, To						-			
. marine			N.M.S. Health Ca 5. Social Security Number 6.		ge (In yrs. la	st hirthday)	If Under 1		rstor If Under		8. Date of B	irth				
	Funeral Director			1□M 2kpF	62	Yrs.		Days	Hours	Min.	NOV 2	ay Ye	1944			
أسا	to the second	į	Usual Residence of Decedent											7705	c virginia	
	how	_	10a. State 10b. County		10c. City,	Town or Lo	cation							1		
	e Ma Ba-f s	Director	Maryland Washir	gton		_			town							
	with the a or 2 be no		10e. Street and Number	a	- 111 4		10f. Zip Co		7.40			10g.			ntry?	
	eath v	Funeral	11 West Baltimon	12. Was Decedent				217		ain? (Cn	ooifu Voo or N				an Indian	
_	fter d	E	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	8-	If Yes, specify	Cuba	in, Mexicai	n, Puerto	ecify Yes or N Rican, etc.)	0-				
12-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 Widowed 4 □ Divorced	1 TYes 2 ☐ If Yes, Give Year or Dates:	196	9	1 ☐ Yes 🏋	□No	Specify:				Specify.	Wh	ite	
Ş	72 ho natur iical i	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Usual (Occupa	ation	t of work	rina	16b	. Kind of Bu	siness/In	dustry	
7	ithin ne.	dr.	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of work DO NOT use				9	Washington of Birth, Day, Year) 27, 1944 9. Birthplace (State or Foreign Country) West Virginia 10d. Inside City Limits 1 □ Yes 2 □ No 10g. Citizen of What Country? U.S.A. or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Restaurant Middle, Maiden Surname) Carter Number, City or Town, State, Zip Code) town, Maryland 21742 20c. Location - City or Town, State Smithsburg, Maryland L. Davis Funeral Home ithsburg, Maryland 21783 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year Did tobacco use contribute to the cause of death?				
7	filed within Hygiene. ther than "	S	17. Father's Name (<i>First, Middle, Las</i>	<i>t</i>)			Waitr	ess		ar'e Nam	e /First Middle	o Maio			nt	
and		Be	Thomas W. Leas						TO. MOUTE		,			<i>5)</i>		
5	d 2 should th and Men 7 is marke traumatic	ို	19a. Informant's Name/Relationship		24222	19b. Mailir	ng Address (S	Street a	and Numbe					State. Zip	Code)	
Ma	ra tra		Paul W. Malcolm	DIC	other -Law										*	
<u>6</u>	- I = =		20a. Method of Disposition		20b. Pla		osition (Name matory or other				Date					
Ē	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		: 1		g Crem			May 20	17, 07	Sn	uithsb	ura.	Maruland	
Баппо	permit. Page Department of Important: If any Injury or once.	1	21. Signature of Funeral Service Lice	ensee		22	2. Name and	Addres	s of Facili			_				
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			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause one cause on each I	d the death. ine.	Do not ent	ter the mode of	of dyin	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Between	
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	/Medical Examiner		resulting in death)	Due to (or as	s a conseque	ence of):	0	7	17		1					
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	tificate be executed g physician and as the burial-transit	Exal	resulting in death) Last	c. Due to (or as	s a conseque	ence of):	ne Jul		rux	a)	11 (1 40	VV			22/	
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	# D 86		IE ECMAL C.													
X Q	the death cert y the attending Iched for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	e pf pregnan 2 Fetal	cy death 3[∃Ectopic preg	nancy							,	
5	at the dea by the at tached fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of dea	ath 5	Other (spec	ify)					NIOI	1111	Day Year	
7	hat th d by detacl		Part II. Other significant conditions	contributing to death I	hut not result	ting in the u	nderlying caus	se aive	en in Part I		23e Did	tobacc	n use contr	ibute to th	ne cause of death?	
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cords	> 9 70	Completed									24a. Wa					
ğ L	e la e 2	du								_	auto	opsy formed		rior to co	mpletion of cause of	
VII	(0 54.		25. Was case referred to medical						00 Di		1□ Yes	2 7	Day Year 2007 2:45 A 4c. County of Death Washington Par) 1944 9. Birthplace (State or Foreign Country) 1944 West Virginia 10d. Inside City Limit 1 X Yes 2 N Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White D. Kind of Business/Industry Restaurant den Surname) Par Staurant den Surname) Par Staurant Home Urg, Maryland 21742 C. Location - City or Town, State mithsburg, Maryland avis Funeral Home urg, Maryland 21783 Approximate Interval Between Onset and Death The Courter of Country Stands of Country Sta			
	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 № No	Hospital:	ient 2∏F	R/Outpatier	nt 3 DOA	Othe			h (Check only		e Doth	or (Consider		
DIVISION OF	g Phys er this eral dir	\vdash	27. Manner of Death	28a. Date of Inj	ury :	28b. Time o		Injun Work		rising ric					y)	
0	Attending Predeath. ector: After to the funerations	atio	N⊒Natural 5 Pending 2 Accident investigation	(Month, Da	ay rear)	Injury	М		Yes 2	No						
<u> </u>		Certification:	3 Suicide 6 Could not I 4 Homicide determined	ne, farm, str	eet, factory, c	office			28f. Location City or To	(Street	tand Number	er or Rura	Al Route Number,			
	spital or ours afte leral Dii filled in	Ç														
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	To the I within 2. To the I complet	Medical	one) 29b. Signature and title of certifier	and manner s						-						
	7 × 5 0	29b. Signature and title of certifier						29c. License number 29d. Date signed (Month, Day, Year) 0 5 - 15 - 2007								
		-	30. Name and address of person who	completed cause of	death (Itom (23a) /Tune	Print)	1	250	-)			4	1	600	
	3	- 1	oo, manio ana address di persori Will	- completed cause of	acam (nem)	Lou, (19pe,	· 1111/									

Registrar
DHMH 17 Rev 1/2001

State

Dr. Khalid Waseem

2007

31. Date filed (Month, Day, Year)

32 egistrar's Signature

1126 Opal Crt. Hagerstown, Maryland 21742

			1 - State Registrar		, , , , , , , , , , , , , , , , , , , ,	Ce	rtificate of	Death		Reg. No.	007	1647.
	Physic	ian	1. Decedent's Name (First, Midd Annie Eva Sy			,			2. Date of D	D	07 ^{Year}	3. Time of Death
P. Maria	/Medi Exami	cal	4a. Facility Name (If not institution Hillhaven Assisted			b Ctr.	4b. City, Town, o	or Location of Deatl		4c. Cou	nty of Death	2:30A. M George's
	Funeral Director		5. Social Security Number 426-34-5004		7. Age (In yrs.	last birthday)	-		8. Date of Bi (Month, D			place (State or Foreign
	Maryland -f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	ce George's		ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 3210 Powder Mil	1 Road			10f. Zip Code 2078	33		10g. Citizen o		•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced		ces? 2X No e		Was Decedent of H If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or Note Rican, etc.)	o- 14. F E Spe	Race - Ameri Black, White, cify:	
1215-0	ithin 72 ho ne. han "natul e Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0.12)	nt's Education est grade completed) College (1-	4or 5+)	(Give		oation during most of wor d)	rking		Business/Ir	ndustry
Baltimore, Maryland 21215-0036	uld be filed w fental Hygie rked other ti ic event, th	To Be Co	17. Father's Name (First, Middle, Claude			Homem verton	акег	18. Mother's Nan	ne (First, Middle		home name)	Harkins
, Mary	ind 2 shoualth and N 27 is mar		19a. Informant's Name/Relations Thomas M. Syke		n			and Number or Ru Green Way				
imore,	Pages 1 an nent of He int: If item int: or other		20a. Method of Disposition 1				sition (Name of matory or other pla n Nationa		Date 5/25/200	20c. Locatio	-	own, State Virginia
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service	Licensee UB age	vard	7 1 4Z	Name and Address Onald V.	Borgward Borgward Mill Ro	dt Funer oad Beli	cal Hom tsville	e, PA Mar	yland 20705
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Alzhe	ch line.	Demen Juence of):	er the mode of dyi	ng, such as cardiad	c or respiratory a	arrest,		Approximate Interval Between Onset and Death Years
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical Examine	that initiated events resulting in death) Last	c	or as a conseq	juence of):						
Box	ne law requires that the death certific has been signed by the attending p ge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 13 months? 1 ☐ Yes 20 No 9 ☐ Unknown		rth 2 ☐ Feta int at time of c	aldeath 3[Ectopic pregnanc	у			Date of deliv	very Day Year
Records, P.O	The law requires that the death ate has been signed by the atten bage 2 should be detached for u		Part II. Other significant conditi	ions contributing to dea	ath but not res	ulting in the u	nderlying cause giv	ven in Part I.		tobacco use co		the cause of death? bably 4 □Unknown
_	The law recate has been appeared; page 2 sho	Completed by							24a. Was auto perf 1 Yes		prior to co death?	opsy findings available ompletion of cause of 2 □ No
Division or Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To Be	3 Suicide 6 Could	Hospital: 1 In In 28a. Date or (Month)	f Injury n, Day Year)	28b. Time o Injury	f 28c. Inju	4 Nursing H	lome 5 ☐ Res 28d. Describe	idence 6 🗆 o	curred	ify) ral Route Number,
2	ospital or a hours after ineral Dire y filled in b		29a. Certifier Certifyi	ng Physician: To the I	best of my kno	owledge, deat	h occurred at the ti	me, date and place	City or To	e cause(s) and	manner as s	stated.
	To the Ho within 24 To the Fu	Medical	(Check only 2 Medical one) 29b. Signature and title of certifie	Examiner: On the ba	e stated.	ation and/or in	29c. Licens	se number	urred at the time	e, date and place 29d. Date sig		
	2		30. Nam and address of person				Print)	2401			7, 200	
	Sta	ate.	Thomas M. Annu.		LO801 I	ature _		#205 Silv	ver Spri	ng, Ma	ryland	1 20901
	Regist		MAY 08		eur L	K So	with					

State of Maryland / Department of Health and Mental Hygiene

		-	1 - For State Registrar			•	e of Death		Reg. No.	7 16474
6	Physicia	an	Decedent's Name (First, Middle, II Bat	ast) cbara	Ann	Schona	t	2. Date of De Month May		ear 07 5:22 A ^M
	/Medic Examin	-	4a. Facility Name (If not institution, g				Town, or Location of		4c. County of	
	LXUIIII	\$20	Frederick Memo:	rial Hospit	al	Fr	ederick		Frede	rick
	Funeral Director		145-28-1168	Sex 7. A	ge (In yrs. last birt	hday) If Under Months	1 Year If Under 2 Days Hours	8. Date of Bir Min. (Month, Da MARCH	y, Year)	. Birthplace (State or Foreign Country) NEW JERSEY
	yland now at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	a-f sh	ctor	MD. FREDER	ICK		FRE	EDERICK			1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of Wha	at Country?
	23a ust b		1210 RUTLED				21703			S.A
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. To fleatin and Mental Hygiene. or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1	?	13. Was Deced If Yes, spen		in? (Specify Yes or No , Puerto Rican, etc.)	Black, Specify:	American Indian, White, etc. WHITE
Ŏ	2 hou	ted	15. Decedent's (Specify only highest	Education	16a.	Decedent's Usu	al Occupation	of working	16b. Kind of Busin	ness/Industry
21215-0036	within 7 ene. than "r he Med	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		rk done during most se retired) EMAKER	or working	HOM	fic
7	filed v Hygie ther t	ပ္	17. Father's Name (First, Middle, La	st)		IMON		r's Name (First, Middle		
ano	d be 1	o Be		,	NNETT					UNK.
Maryland	2 should and Men is marke aumatic	은	19a. Informant's Name/Relationship			. Mailing Address	(Street and Numbe	r or Rural Route Numb	er, City or Town, St	ate, Zip Code)
S	nd 2 salth au 27 is 27 is rtrau		WAYNE R. BOWKE	R.SR./SON	1	210 RUTI	LEDGE PL.	APT. 1D. F	REDERICK.	MD. 21703
ē,	es 1 a of Hec of Hec Fitem rothe		20a. Method of Disposition		20b. Place of	Disposition (Narry, crematory or o	me of	Date	20c. Location - Ci	
Ë	Page nent c nt: If nry or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	MAY 8,2007	RIVERDA	LE, MD.				
Baltimore,	permit. Pages Department of Important: If I any Injury or once.	İ	21. Signature of Euneral Service Lie	nd Address of Facility	L HOME & C	REMATORIU RDALE, MD	M,P.A. 0. 20737			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	e of dying, such as		rrest,	Approximate Interval Between Onset and Death			
68760,	rificate be executed g physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence					
. Box	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 ☐ Fetal death at time of death	3 ⊟Ectopic p 5 ⊟ Other (s _i			23d. Date Monti	
	Se 16 ec	by	Part II. Other significant condition	s contributing to death	but not resulting in	the underlying o	cause given in Part I.			ute to the cause of death? ☐ Probably 4 ☐Unknown
l Rec	The law ate has b page 2 sh	Completed						24a. Was auto perfi 1 Yes	psy pri prmed? de	ere autopsy findings available or to completion of cause of ath?]Yes 2 \(\) No
Viita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	tient 2 T FR/O	rtpatient 3 □ D0	Other:	of Death (Check only		(Specify)
n 0r		on: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In	jury 28b.		28c. Injury at Work?		how injury occurred	
-	or Attenctive death	Medical Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion t be 28e. Place of ii	njury - At home, fa etc. <i>(Specify)</i>	M rm, street, factor	1 ☐ Yes 2 ☐ y, office	28f. Location	on (Street and Number or Rural Route Number, Town, State)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	dical C		Physician: To the best	of examination ar					
	Fo th within Fo th compl	Me	29b. Signature and title of certifier	8			c. License number			(Month, Day, Year)
	2		→ €				D4309	(5-6-	67
-)		30. Name and address of person w	ho completed cause of	death (Item 23a)	(Type, Print)	i Hous	e Ave,	Frede	o7
P	Sta		31. Date filed (Month, Day, Year)		trar's Signature	1 4				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year Physician рМ 6, 2007 May 2:00 /Medical Saia Francis Anthony Saia
4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's

9. Birthplace (State of Country) 1003 Fairview Avenue ocial Security Number 6. Sex Takoma Parl Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 XM 2 ☐ F 579-24-4338 81 16, 1926 Washington, Jan. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State a or 28a-f show t be notified at 1 ☐ Yes 210 No Director Takoma Park Prince George's Maryland 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20912 USA ral", or items 23a Examiner must b 1003 Fairview Avenue permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. I limportant: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Event once. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: Completed by 1943-46 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed 8 Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Oddo Martino Saia ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peter A. Saia/ Son 12614 Hillmeade Station Drive, Bowie, MD 20720 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 10, May 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 ☐ Donation _ 5 ☐ Other (Specify) 2007 Brentwood, Maryland 21. Signature / Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final **Physician** Lymphoma resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 **J**No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 1 ☐ Yes 2 ☐ No death. 24 hours after deat

P.O. Box 68760. Division or Vital Records,

the Hospital completely within 24

filled in by

Medical

31. Date filed (Month, Day, Year)

MAY

5 Pending investigation 2 Accident

6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

and manner states 29c. License number 29d. Date signed (Month, Day, Year) d title of certifier 29b. Signature May 7, 2007 D64615 nencon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 8 2007

1355 Piccard Drive, Rockville, MD 20850 Genevieve Wroblewski, M.D.

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Eugene Shumaker, Jr. 2007 10:15 M May /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Health Care Center Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 🛣 M 2 🗆 F 40 212-96-2002 May 13, 1966 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Washington 1 ☑ Yes 2 ☐ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Mill Street 21740 by Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 X Never Married 2 Married

1 Yes 2 No

Laborer

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify:

18. Mother's Name (First, Middle, Maiden Sumame)

Delinda Lee Cooper

56 East Baltimore Street, Hagerstown, Md. 21740

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5/10/2007

Specify: White

Construction

20c. Location - City or Town, State

Hagerstown, Maryland

65-07-2017

16b. Kind of Business/Industry

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahrowany injury or other traumatic about the statement of the statement in th Baltimore, Maryland 21215-0036

Completed

Be

Funeral

Director

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

12

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

³ 4 □ Donation 5 □ Other (Specify)

19a. Informant's Name/Relationship (Type, Print)

15. Decedent's Education

(Specify only highest grade completed)

Edward Eugene Shumaker, Sr.

Terresia D. Seibert/Sister

1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4or 5+)

Priysician /Medical Examiner

> Examiner physician and the burial-transit by Physician/Medical Be Completed Medical Certification; To filled in by the funeral after death

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

21. Signatura Funeral Service Lice	1 11.	Name and Address of Facility I		uneral Chapel erstown, Md. 21742
23a. Part1. Enter the disease, or conshock, or heart failure. List online mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): c. ue to (or as a consequence of): d.	the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death 6 D
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	ise contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
1 ☐ Yes 21 StNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	O++	Home 5 Residence	S Other (Specify)
27. Manner of Death 1 □ □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		t, factory, office	28f. Location (Street and City or Town, State	d Number or Rural Route Number,
29a. Certifier Certifying P	miner: On the best of my knowledge, death o miner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	7	e signed (Month, Day, Year)

5H-Registrar

31. Date filed (Month, Day, Year), MAY 11 2007

Muhammad Waseem, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1126 Opal Court, Hagerstown, Md. 21740 32. Pegistrar's Signature

DHMH 17 Rev 1/2001

State

24 hours a

within 2 To the

			1 - For Amend	#29d, per	State of I verbal DHF	Marylan B, per N	nd / Depá 10, Geo/	artmen	당 e of L	ealth a	and M	lental Hy	gieņe Rog. No.	00	7	16477
	Physici		Decedent's Name GEORGE EL	(First, Middle, La	st)						-	2. Date of De Month 5		-	2007	3. Time of Death 21:58P M
	/Medic Examin		4a. Facility Name (# 1 14431 MIL			er)		4b. City.		Location o	of Death			County o		
	. Funeral Director		5. Social Security Nu 220-28-97 Usual Residence of D	52	Sex 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bii	rth 3y (9 <i>ar)</i>	F	9. Birthpl Count ENNS	ace (State or Foreign YLVANIA
	Maryland -f show	tor		10b. County ALLEGAN	7		y, Town or La								10	od. Inside City Limits
	th with the 23s or 28s	Funeral Director	10e. Street and Numi		1M			10f. Zip 2153							hat Count	
9800	ba filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23c or 28a-f show event, the Malfall Examiner instructional.	by	11. Marital Status 1 Naver Married 3 Widowed 4		12. Was Decede Armed Force 1 X Yes 2[If Yes, Give Year or Date	s? ¬ No		Was Deced f Yes, spec 1 ☐ Yes 2	ify Cubar	spanic Orion, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)		Black	- America c, White, e WHIT	tc.
Maryland 21215-0036	filed within 72 h Hygiene kther then "netu ent, Ine Marical	Completed	(Specify Elementary/Second	15. Decedent's E y only highest gra dary (0-12)	ducation ade completed) College (1-4d	or 5+)	life. I	dent's Usua kind of wor DO NOT us CHINIS	k done d e retired)	urina most	of work	ing			SHOP	ustry
yland	should ba filk and Mental Hy marked oth umatic event	To Be (18. Mother's Name (First, Middle, Maiden Sumame) GEORGE W. SMEARMAN 19a. Informant's Name/Relationship (Type, Print) WILLIAM SMEARMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 15148 MAIN STREET, HYNDMAN PA 15545													
	is 1 and 2 should of Health and Meritem 27 is market other traumatic		WILLIAM SM	IEARMAN			15148	MAIN	STRI	EET,	HYND	MAN PA	1554	.5		
Baltimore,	t. Page rtment o rtant: If rjury or		1 🌠 Burial 2 🗆 `4 🗆 Donation 5	A. Method of Disposition 1 Note of Disposition 1 Note of Disposition 1 Note of Disposition 1 Note of Disposition 1 Note of Disposition 1 Note of Disposition 1 Note of Date 20c. Location - City or Town, State COVE, MD 21 Note of Disposition 22 Note of Disposition 23 Note of Disposition 24 Donation 5 Other (Specify) 25 Note of Disposition (Name of Other Place) 26 Note of Disposition (Name of Other Place) 27 Note of Date 28 Note of Disposition (Name of Other Place) 29 Note of Disposition (Name of Other Place) 20c. Location - City or Town, State COVE, MD 27 Note of Disposition (Name of Other Place) 28 Note of Disposition (Name of Other Place) 29 Note of Disposition (Name of Other Place) 20c. Location - City or Town, State COVE, MD 20c. Note of Disposition (Name of Other Place) COVE, MD 21 Note of Disposition (Name of Other Place) 20c. Location - City or Town, State COVE, MD 20c. Location - City or Town, State COVE, MD 21 Note of Disposition (Name of Other Place) 22 Name and Address of Facility SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532												
Ba	Dermi Depa Impo		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.											RG, M		
68760,	the death certificate be executed when the attending physician and the attending physician and the attending burial-transit	edical Examiner	Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intriated events resulting in death) Last DIABETES WITH COMPLICATIONS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Interval Between Onset and Death				
.O. Box		Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	Ectopic pre					2	23d. Date Mon	of deliver	y Day Year
rds, P	sign sign d be	by	Part II. Other signific HYPEI	ant conditions of RTENSION	ontributing to death	but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.			obacco u		bute to the	cause of death?
Vital Records,	24a. Was an autopsy performage? Q Q Q Q Q Q Q Q Q								sy findings available pletion of cause of							
f Vit	Physician: T this certificat ral director, pa	To Be	25. Was case referre examiner? Yes 2 N		Hospital:	utient 2	ER/Outpatien	t 3□ DO.	A Othe		of Death	ne Sa Resi		i Othe	r (Specify)	
Division of	ding After fune	ertification;	27. Manner of Death Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigation			28b. Time of Injury	М		at ? es 2 □ N	40	28d. Describe				
Divi	in the part of	O	4 Homicide	determined	building,	etc. (Specify	y) 					28f. Location (, City or To	wn, State)			
	To the Hospital within 24 hours a To the Funeral Completely filled in	ledical	(Check only 2 one)	Medicel Exer	ysician: To the be niner: On the basis and manner	of examina	wiedge, death tion and/or inv	estigation,	in my opi	nion, deat	d place, a h occurr	and due to the ed at the time,	date and	place, ar	nd due to t	he cause(s)
)	To witi	Σ	29b. Signature and til	tte of certifier	Mur			-	C 9				A 1 1	_	(Month, D 207	ay, rear)
_			30. Name and address	ss of person with	completed cause o	f death (Item		Print) Br	7	57	(ano	FACI	~	بمسمر	
	Sta Registr		31. Date filed (Month	Ay Toary 2	007 32 Regi	strar's Signa	And And	ale								

			1 - For State Registrar			t Maryla		artment of rtificate of			lental Hy	/giene Reg. No.2	107	16478	
	Physici		1. Decedent's Name (First Chingtao Ta		st)						2. Date of Do	Day	Year	3. Time of Death 4:45 PM	
	/Medio		4a. Facility Name (If not in		e street and nui	mber)		4b. City, Town,	or Location	n of Death	na	4c. Cour	nty of Death		
بسنت				nts Grov					h Poto				ntgomer	у	
	Funeral Director		5. Social Security Numbe 219-68-3994 Usual Residence of Dece	4 1	ex M 2□F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yea Months Days		er 24 Hrs. Min.	8. Date of Bi (Month, Di June 21	ay, Year)	Cour	place (State or Foreign htry) in, China	
	/land			County		10c. C	City, Town or Lo	cation					1	0d. Inside City Limits	
	a-f sh	ctor	Maryland I	Montgome	ry		North	Potomac						1 □Yes 2X No	
	or 28	Director	10e. Street and Number					10f. Zip Code				10g. Citizen o	f What Cour	ntry?	
	s 23a nust I	eral	14 Flints	s Grove		ada at Fire in I	110		20878				J.S.A.		
36	be filed within 72 hours after death with the Maryland Hygiene. 4d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D	_	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	rces? 2☑ No ⁄e		Vas Decedent of fYes, specify Cu I□Yes 2⊠ No			ecify Yes or No Rican, etc.)	0- 14. H B	ace - Americ lack, White, cify:	etc.	
9	2 hou latura ical E	ted	15. D	ecedent's Ed	ucation		16a. Deced	lent's Usual Occi	upation			16b. Kind of		Asian dustry	
Maryland 21215-0036	d within 7 giene. r than "n the Medi	Completed	(Specify on		de completed) College (1	-4or 5+)	(Give life. L	kind of work don OO NOT use retir Owner	e during mo ed)	ost of worki	ng	Cift	Shop	•	
		Be C	17. Father's Name (First,	Middle, Last)					18. Moti	her's Name	(First, Middle	, Maiden Surn			
<u> </u>	2 should be filed word and Mental Hygie Is marked other traumatic event, th	힏	Tsen Ug								se Ling				
Mar	d 2 sh th and 17 Is m traum		19a. Informant's Name/R					g Address (Stree					·	·	
ā,	s 1 an f Heal ftem 2 other	1	Litsun L. 3 20a. Method of Disposition		ouse	20b.	Place of Dispos	nts Grove	- 1		Potomac ate	Marylan 20c. Location			
Ē	Page nent o int: If iry or		1 🔀 Burial 2 □ Crer 4 □ Donation 5 □ 0			State Par	rklawn Me emorial G	natory or other plane morial Par ardens	rk &	5/10/2	2007	Rockvill	e Mars	rl and	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Funeral	Service Licen	see		22 Hi	Name and Addr	di Fune	lity eral Ho	me, Inc.			rland 20904	
Fac.	Physician /Medical Examiner		23a. Part1. Enter the disc shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	re. List only o	a.	ach line.	ith. Do not ente	er the mode of dy	in g , such a	is cardiac o	r respiratory a	rrest,	8,	Approximate Interval Between Onset and Death	
68760,	cate be physicia the bur	edical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying cause. Unclease of injury that initiated events resulting in death) Last	s, the	C	or as a conse				1					
DOX.	attending for use	Physician/Me	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iaiii		irth 2□Fet ant at time of	al death 3	Ectopic pregnand Other <i>(specify)</i> _	ру				ate of delive	ery Day Year	
coras, r	w requires that the de been signed by the s should be detached	2	Part II. Other significant (conditions co	entributing to de	ath but not re	sulting in the un	derlying cause gi	ven in Part	i.				ne cause of death?	
Lec	ine law re ate has bee page 2 sho	ompleted				-					24a. Was auto perfo	psy ormed?	prior to cor death?	psy findings available npletion of cause of	
VII.a	ertifica ector,	BeC	25. Was case referred to examiner?	1					26. Plac	e of Death	(Check only o		TLITES	2 140	
	r this certific ral director,	욘	1 ☐ Yes 2 ☒ No 27. Manner of Death				ER/Outpatient	3 DOX				dence 6 □0)	
	Attending ir death. ector: After by the funer	Certification:	1 ☑Natural 5 ☐ 2 ☐ Accident	Pending investigation Could not be	7	h, Day Year)	28b. Time of Injury		Yes 2		8d. Describe	how injury occu	irred		
= :	urs after d ral Direc														
the Heat	To use no speptial or Amending Priysician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ledical	one)	edicai Exam	sician: To the iner: On the ba and mann	isis of examin	owledge, death ation and/or inv	estigation, in my	opinion, de	and place, a	and due to the ed at the time,	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)	
1,		Σ						29c. Licen:	se number 064615			29d. Date sign May 4		Day, Year)	
t,			30. Name and address of			•		•							
	Stat	e_	Genevieve W 31. Date filed (Month, Day	Year)	32 Re	gistrar's Sign	ature		Kockvi	11e, M	aryland	20855			
	Registra		MAY	0 8 200	7	Person 1	K Low	AS D							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per dr., g870,08/16/07dhb
Reg. No. For State Registra Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Katie H. Tyler 2007 11:40 P[™] <u>April</u> 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 8. Date of Birth (Month, Day, Year) 9. Birthplas (Country) Feb. 16, 1908Washington, D.C. 6. Sex If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 ☐ M 2 🗓 F 579-07-0961 Director 99 Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits r then "netural", or items 23a or 28a-f shorting Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a r 224 Windjammer Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Ď 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Unknown Molly Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Itsm 27 is sny injury or other trau 900. Mary E. Hoal (daughter) 224 Windjammer Rd., Ocean Pines, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. | May 3,2007 Frankford, DE 21. Signature Juneral Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebro vascular accident /Medical Examiner Der Tonsio if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a n equence of) ettending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death ed by the e 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete has Lifrector, page 2 s 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital 2 No : After this certifice a funeral director, (25. Was case referred to medical 26. Place of Death | Check only one | Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred Division s after de. 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital or within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number

State Registrar GREGORY

Day, Year)

31. Date filed (Nonth,

D56312

ttending

empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Slamnas

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amendati tems a viano Pesepartalent of Health any Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** CLAYTON 05 09 2007 1900 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS -BRADDOCK CAMPUS ALLEGANY CUMBERLAND 1929 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1929 (Month, Day, Year) Nov 18, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ F Director 463-34-4083 Usual Residence of Decedent a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐Yes 2☐No MD Allegany Cresaptown Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA rai", or items 23a Examiner must b 14301 Winchester Road by Funeral Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.

wit; If item 27 is marked other than "naturai", or items 23, and it if item traumatic event, the Medical Examiner must any or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: 3x Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pipefitter Kelly Springfield Tire 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rueben James Via, Sr. Ruth Isabel Via ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21542 granddau. P.O. Box 235 Midland Nancy Supinsky step 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 5/15/2007 MD Cresaptown 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ARTERIOSCIENOTIC CALDIOVAICULAR DIFFIF YEARI /Medical Due to (or as a consequence of): Examiner NYPENCHOLESTENOLEMIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Į, in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1□Yes 2□No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by iskichtiv. 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No TOBACCO USE 24a. Was an autopsy performed? 1 Yes 2 No STENUSIS ACKTIC or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 \ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospitai E-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donaldson 912 m.D Drive, Cumberland, MD, 21502 31. Date filed (Month, Day, Year) MAY 2 1 200 32. Registrar's Signature State

Registrar

9.5		For State RegIstrar 1. Decedent's Name (First, Middle, La			epartment of Certificate of		-	Reg. No. 20	07 164		
Physician /Medical Examiner	1	Margarit 4a. Facility Name (If not institution, giv	a M.	Vallar		or Location of Death	2. Date of De Month May	_			
Funeral Director		Usual Residence of Decedent		(In yrs. last birtho	(ay) If Under 1 Year	r If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct. 1	Mont 9 7,1909 C	gomery Birthplace (State or Fore Country) olombia		
the Marylan 28a-f show notified at	_ 1	10a. State 10b. County MD Montgom 10e. Street and Number		10c. City, Town o	ersburg				10d. Inside City Lim 1 ☐ Yes 2 📉		
r death with ems 23a or er must be	2	51 Portside Cour	t 12. Was Decedent Ev Armed Forces?	er in U.S.	10f. Zip Code 13. Was Decedent of If Yes, specify Cu	20877 Hispanic Origin? (Sp		10g. Citizen of Wha United S 14. Race - /	tates American Indian,		
2 hours afte atural", or it al Examin	2 6 20	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Ed	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 X Yes 2 □ No	SpecifColon		Specify:	White, etc. White		
be filed within 72 hours after death with the Mar tall Hygiens tall Hygiens do other than "natural", or Items 23a or 28a-f si event, the M-dical Examiner must be notified event, the M-dical Examiner must be notified Be Completed by Funeral Director	-	(Specify only highest gra Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(G lii	ive kind of work done e. DO NOT use retire nemaker	e during most of work ed)		Own Home	•		
should be find Mental Haraked of umatic even	!	Maximino Gomez 19a. Informant's Name/Relationship (19b. M	ailing Address (Stree	Sara 0	rtiz	Maiden Surname)	to Zin Codel		
permit. Fages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the M-di-al Examiner must be notifiled at once. To Be Completed by Funeral Director		Fanny Vallarino (1 20a. Method of Disposition 1	Daughter)	51 20b. Place of Di	Portside sposition (Name of crematory or other place)	Court Gai	thersbur	rg, MD 208 20c. Location - City	or Town, State		
Departme Departme Important any injury once.		21. Signature of Funeral Service Licen		Gate of	Heaven Ce 22. Name and Addr 10 East D	ess of Facility De	Vol Fune	eral Home	pring, MD MD 20877		
ding physician and se as the burial-transit and se the burial-transit and se the burial-transit and the burial-tra		23a. Part1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, fair,	b. Conjesti Due to (or as a c Lischemic Due to (or as a c Due to (or as a c Due to (or as a c Due to (or as a c	ve Heart consequence of): Cardion consequence on, sion	Failure	ng, such as caldiac (or respiratory and	rest,	Approximate Interval Between Onset and Death Days Years Years		
d for u	1 2	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf p 1 □Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death	3□Ectopic pregnanc 5□ Other (specify) _	у		23d. Date of Month	delivery Day Year		
een signed by the nould be detache red by Phys	1	art II. Other significant conditions co	ntributing to death but n	ot resulting in the	underlying cause giv	ven in Part I.			to the cause of death?		
this certificate has been s ral director, page 2 should To Be Completed		5. Was case referred to medical examiner?				26. Place of Death		gy prior to death 2 🕅 No 1 □ Y	autopsy findings availat o completion of cause o ? es 2 □ No		
Vitter tunera	2	27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 2 \(\text{Accident} \) 3 \(\text{Suicide} \) 6 \(\text{Could not be} \) 28a. Date of Injury (Month, Day Year) A Noticity M 28b. Time of Injury M 1 \(\text{Yes} \) 1 \(\text{Yes} \) 2 \(\text{Injury at Work?} \) 1 \(\text{Yes} \) 2 \(\text{Injury at Work?} \)							e 5X Residence 6 Other (Specify) 3d. Describe how injury occurred		
within 24 hours after death. To the Funeral Director: X completely filled in by the fi Medical Certificati	2	9a. Certifier 1 🕅 Certifying Phy	sician: To the best of m	ny knowledge, de amination and/or	ath occurred at the til	mo data and ulcas	City or Town	n, State)			
the dec	2	9b. Signature and title of certifier	and manner stated		29c. Licens			9d. Date signed (Mo			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** May 16, 2007 12:30 P Louis Valenzano /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17219 Porter Road Allegany **Eckhart** If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 ☐ F 219-14-5626 Director 85 Maryland May 12, 1922 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla andment of Heatih and Mental Hygiene. iortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 ☐ No Director Maryland Allegany Eckhart 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17219 Porter Road U.S.A by Funeral 21528-12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ₩ ₩ ፲፲ 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 special agent Internal Revenue Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Valenzano Maria Sassone ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trees. Ernestine A. Valenzano sister 17219 Porter Road 21528-**Eckhart** Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Saint Michael's Cemetery Frostburg 4 ☐ Donation 5 ☐ Other (Specify) May 18, 2007 Maryland 21. Signature of Funeral Service Lig 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final ARCINUM A Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Yea 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🔲 Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA

Division or Vital Records, P.O, Box 68760.

Baltimore, Maryland 21215-0036

certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

D. 3

X State 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

27. Manner of Dath

1 Natural

3 Suicide

29a. Certifier

4 Homicide

2 Accident

Certification;

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bishop

31. Date filed (Month, Day, Year) 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May Month Harold P. Weinberg 200^{Year} 12:38P. M 3, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Suburban Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 15√M 2□F Aug. 23, 1925 Newnyork 226-20-6059 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Montgomery Rockville 1 ☐ Yes 2 X No Director 10f. Zip Code 20852 10g. Citizen of What Country? United States 10e. Street and Number 11410 Strand Drive, #314 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer VSE Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Weinberg Jane Rosen 19b. Mailling Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 520 North and South Road,#304 University City, MO 63130 19a. Informant's Name/Relationship (Type. Print) Barry Weinberg- son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State King David Memorial Gardens 5/6/2007 Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA oneld 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR FIBRILLATION **Physician** /Medical Due to (or as a consequence of): Examiner CONGEST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran and Due to (or as a consequence of). Wen berg, Lawld 1238 pm. Division of Vital Records, P.O. Box 68760, the attending physician law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No After this certificate has autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 00057124 Sa MA 5/4/0> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D. 9715 Medical Center Drive, #201 Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 0 8 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Lest) 2 Date of Death 3 Time of Death Month **Physician** INHITE 13. 12:00 JEHNNETTE 2007 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BRADDUCK HEIGHTS FREDERICK HOME VINDOBOUA NURSWG If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign __Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min 05-02-1920 86 577-30-6090 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 💢 No Director VA Shenandoah New Market 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 205 Battlefield Bluff Dr. 22844 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White à 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Cafeteria Worker Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (G. Frank Blosser Mary Rinehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald W. White 205 Battlefield Bluff Dr., New Market, VA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Omps Cremation Service 04-25-07 Winchester, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Omps Funeral HOme, 1600 Amherst St., Winchester he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIOPULMONARY IMMEDIATE Examiner Due to (or es a consequence of): Examiner MZHAMARS DEMENTIA LEXER attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No ģ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death. Director: Af

Be Completed

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death
1 Natural 5 Pending investige 2 Accident Suicide 4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of certifies Hospital: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred investigation 1 ☐ Yes 2 □ No Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. eted cause of death (Item 23a) (Type, Prinj 30. Name and address of person who com-

2007

Mn

16675

MD

29d. Date signed (Month, Day, Year)

APRIL 23, 2007

MIN 31. Date filed (Month, Day, Year)

MUGALER Registrar's Signature

Hospital 24 hours a

within 2

			State of Maryland / Department of Health and Mestate Amend #2 & #3 per PHYS 05-09-2007. CNM Certificate of Death	ental Hygien Reg. N	2007 16486
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Edna Mae Wedon	2. Date of Death Month May D	04, 2007 3. Tige: 03ain
	Examir Funeral Director		Months Days Hours Min.	B. Date of Birth (Month, Day, Year	c. County of Death Frederick 9. Birthplace (State or Foreign Country) M.D.
	e Maryland a-f show tifled at	ctor	10a. State 10b. County 10c. City, Town or Location M.Cl. Frederick Frederick	· · · ·	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28 1st be no	Funeral Director	10e. Street and Number 4328 Buckeystown Pike 10f. Zip Code 21701	10g. C	itizen of What Country?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Maritai Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Specify Cuban, Mexican, Puerto River Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Research or Specify Cuban, Mexican, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto River Yes, Specify Cuban, Puerto	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
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e, Mar	is 1 and 2 sho of Health and item 27 is m other traum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural I 19c. Mailing Address (Street and Number or Rural I 19b. Mailing Address	hambers	burg Pa. 17201
Baltimor	Page ment o ant: If ury or	3	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Nava Memory 8, 2	2007 Fu	
Ba	permit. Departr Imports any inj	8 5	21. Signature of Funeral Service License Claims 22. Name and Address of Facility GAR 110 WEST SOUTH ST	FREDE	RICH MD 21701
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Tenal	respiratory arrest,	Approximate Interval Between Onset and Death
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P,O. Box 68	The law requires that the death certifica te has been signed by the attending phage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEART FALLIE		use contribute to the cause of death?
or Vital Records,		Completed		24a. Was an autopsy performed? 1∐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ion or Vit	ding Phys 1. After this funeral dir	ation: To Be	07.44		6 □Other (Specify) iry occurred
Division	i i i i	Certification:	# nornicide building, etc. (Specify)	City or Town, Stat	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	I at the time, date an	nd place, and due to the cause(s)
	Vith Con	N	29b. Signature and title of certifier assure 29c. License number 29c. License number 29c. License number	29d. Da	May 07
	4		29b. Signature and title of certifier 29c. License number 10 40 3 0 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUCTURE CASHERANIAE 1564 OPPOSSUTEN FILE PRODUCK I	MD 21701	,
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	/Medi	cal	1 NA WERRE 4a. Fecility Name (If not institution, give			45 Cit. T		Non-A Death	05	08	2007	0225 A M
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	Funeral	Г	5. Social Security Number 6. Se		vrs. last birthday)	If Under 1 Months		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da	h		place (State or Foreign
l.	Director		219-80-5652 Usual Residence of Decedent	44	Yrs.				Aug 9,	1962	Ma	ryland
	ryland how		10a. State 10b. County	10c.	City, Town or Lo	ocation					1	0d. Inside City Limits
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	with the or 2	by Funeral Director	10e. Street and Number	0	7	10f. Zip C				10g. Citizen of		•
	death me 23	nera	7901 Laurel Lakes	12. Was Decedent Ever i			0707 nt of Hispanio	c Origin? (Spe	ecify Yes or No Rican, etc.)	United 14. Ra	ce - Americ	
9	or Ite	/ Fur	1 ☐ Never Married 21 Married	Armed Forces? 1		If Yes, specify 1 ☐ Yes 2)X		xican, Puerto	Rican, etc.)		ick, White,	
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Ball	permit. Pages 1 end 2 Depertment of Heelth ar Important: If item 27 le eny Injury or other treu ong.e.		21. Signature of Funeral Service Ligens	M00969	9 28	Name and A lendon- 18 E.	Address of F Bailey Baltin	acility y Funer more St	al Home	P.A.	Maryl	and 21224
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Вох	The law requires that the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	200. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F		Ectopic pregi				23d. Da	ite of delive	ry
ю. В	at the deat by the atte	sicia	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4□Pregnant at time of		Other (speci				Mo	onth	Day Year
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ion	Attending r death. sctor; After by the funer	atlor	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)) Injury	м	Injury at Work? 1 □ Yes 2		ou. Doscribe ii	ow injury occur	160	
Division of Vital Records,	P affe	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, streetify)	eet, factory, o	ffice	2	8f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,
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State of Maryland / Department of Health and Mental Hygiene

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	Exami			Matthew W. W	atson							May 5, 200		unty of D			
			4a.	. Facility Name (if not institution, g	ive street and numb	er)	1	tb. City, Tow College			Death		Prince George's				
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	Funeral		5.	Social Security Number 6.	Sex 7.	Age (In yrs. last	birthday)	Months	Days	Hours	Min.]F	oreian		-
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				ual Residence of Decedent		10c. City, To	own or Locat	ion					10d. Inside City Li				Limits
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	or dea	μ			1 Yes	2 X No	1	Yes 2	X No	specify:			Spe	ecify: V	White		
	led within 72 hours after Hygiene. other than "natural", the Medical Examiner	2	-	15. Decedent's Education (Specify	Lor Dates:	completed) 1	6a. Decede	nt's Usual Oc	ccupation	on (Give k	ind of wo	ork done	done 16b. Kind of Busines			ustry	
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215	uld be fill Mental H marked c event, t	8	3	Gavin M. Wat	son		T 401 14 11	Address	(C)			urai Route Nui		or Town.	State, Z	ip Code)	
21	and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner.	15	2 7	9a. Informant's Name/Relationship Barbara Winter 1	o (Type, Print)	ther	196. Mallil	ng Address	(Street	ll Ct	E. E	Illicot	t Cit	y, 1	4D :	21042	
M	id 2 sh ilth ar m 27 auma							sition (Name				Date				wn, State	
<u>q</u>	s l an of Hea If ite	l	1	0a. Method of Disposition Burial 2 Cremation	3 Removal fro	m State cr	ematory or o	other place)			5/11	/2007	Cat	ัดทรา	zi11a	e, MD	
Ē	Pages I and 2 shoul ment of Health and N tant: If item 27 is n or other traumatic	l	4	Donation 5 Other Spe	cify:	IMet.		mator	_	of Facility							
Raltimore	permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:		2	1. Signature of Funeral Service L	mcensee MC	1442	22.	Manie and A	7 7 4	~ 1	Harr	y H. W	itzke	'S I	damı.	TA LH	21043
,		_		3a. Part I. Enter the disease, of co	omplications that ca	used the death. I	Do not enter	the mode of	dying,	such as c	ardiac or	respiratory ar	rest, shock	, or hea	T Y	Approximate Between Or	Interval
•	'sician		- 1	failure. List only one cause o	II Cacii iii ic.											Deat	
E	xamine		1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of)):										
		Convertible list conditions b.													\rightarrow		
			<u>ا</u> وَ	if any, leading to immediate	Due to (or as a	consequence of):										
-		1	티	cause. Enter Underlying Cause (Disease or injury that initiated	C. Due to (or as a	consequence of):										
	ted 1 1 1 1 1	١,		events resulting in death) Last	d.												
	cate be executed physician and transit	a .	Medical	UNPENDED	AMENDED		_										
ç	ot, ate be hysici	ino a	P F	IF FEMALE:	23c. If yes,	outcome of pregr	nancy							Date of fonth	delivery Da	av '	Year
7	rtifica ling p	as the	Jua 2	3b. Was decedent pregnant in the past 12 months?	Person			Fetal death				"	noriu i	De	27		
	leath certific e attending	or us	Sici	1 Yes 2 No 9 Unk		Pregnant at time of death 5 Other (Specify)											
ב	the de	2	Physician/	Part II. Other significant condition			esulting in th	e underlying	cause	given in F	Part I.					ne cause of c	
(ires that the signed by t					_						1 Y	es 2 🗸			ably 4 L	
	duire equire	nid	te									24a. Wa	is an opsy	24b. \	Vere auto prior to co	opsy findings empletion of	cause of
	SOF law re has by	S Sho	힐										formed?		death?	s 2	No
ſ	The ficate	, page	Completed by						26.Plac	ce of Deat	h (Check						
	Division of Vital Records, P.O. Box bolow, tall or Attending Physician: The law requires that the death certificate be executed as after death. The This certificate has been signed by the attending physician and an Director. After this care as the bring - Italisis.	filled in by the funeral director, page 2 should	۵j	25. Was case referred to medical examiner?	Lie e-ital:	Inpatient 2	ER/Outpati	ent 3	OA	Other;	Nursi	ng Home 5	Resider	ice 6	✓ Other:	Scene	
	Phys Phys	eral di	의	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time	of Injury	28c. Inj	jury at Wo	rk?	28d. Describ Occupant	e how inju	ry occur to coll	ed ision		
	on of the state of	e fun	ë	1 Natural 5 Pend	ling May 5,	2007	0325 hrs		1	Yes 2	/ No						
	Sion Attend rector:	by th	icat		stigation 28e. Pla	ce of Injury - At h	ome, farm, s	street, factory	, office	building,	etc.					ral Route Nu	
	Div rs after ral Div	led in	Certification:	4 Hamiside deter	rmined (Specify	Major Roa						Metzerott F	kd and Un				K, MD
	Hospi 4 hou	8	٥	20a Certifier	hysician: To the be	est of my knowled	ige, death o	ccurred at the	e time,	date and	place, an	d due to the c	ause(s) and	manne	r as state	ed. e cause(s)	
	To the P within 2 To the 1	completely	one) 2 Medical Examine on the basis of examination and/or investigation, in my opinion, death occurred at the									at the time, da	ate and pie	oo, and		nth, Day, Yea	r)
	15. ≥ 15.	8	Me	29b. Signature and title of certific				29		nse numb	er					mii, Day, rea	1)
				. 1//	1				0.0	C.M.E.			lviay	5, 20			
6.1	100			30. Name and address of person	who completed ca	use of death (Iter	m 23a)	444.5	<u> </u>	- L D 111	mer-	MD 24204					
6				Mary G. Ripple MD.	Deputy Chief	Medical Exa	miner	111 Penn	Stre	et, Balti	more,	MD 21201					
			ate	100 100 100 100 100 100 100 100 100 100	9 2007 32.1	istrar's Signal	ture	book	9								
	Reg	gist	rar	MIMI	J 200.												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 18, 2007 ELSIE Ρ. 11:35 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manokin Manor Nursing & Rehab Center Princess Anne Somerset If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) April 25, 1920 **Funeral** 9. Birthplace (State or Foreign 1 M 2 TXF Director 218-07-5434 Yrs. 86 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avant, the Madical Extentions of the notified at 10d. Inside City Limits Director 1X Yes 2 No Maryland Somerset Crisfield 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 315 Somers Cove Apartments 21817 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 🖔 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or othar traumatic avant. It a Mexical permits and injury or othar traumatic avant. It a Mexical permits a permits and injury or othar traumatic avant. Elementary/Secondary (0-12) College (1-4or 5+) 8 Manager Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Edward Parks Sally Marie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Seyda (Daughter) 325 Somers Cove Apartments - Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Sunvride Memorial Park April 22, 2007 Crisfield, Maryland 21. Signature of Euneral Saprine Licensee

Mary Both Bradshaw—Pruite 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician **ASCVD** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medlcal the ! IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 🖾 No 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 🗌 Yes 2 X No of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 X Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) D 47094 April 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. - 1415 S. Division Street - Salisbury, MD 21804 Vel Natesan, 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

9 2007

			For State Registrar	State o	f Mar		-	tment of Hificate of I		nd M		ene 9. No. () ()	7	16490	
	Physici		Decedent's Name (First, Midd. Rose Zang	e, Last)							2. Date of Death Month 5/6/0	7 Day	Year	3. Time of Death 11:30a м	
	/Medic Examir		4a. Facility Name (If not institution			d not an		4b. City, Town, or		Death			4c. County of Death Montgomery		
	Funeral Director		Hebrew Home o: 5. Social Security Number 030-07-3289	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. last birthday) If Under 1 Year If Under 24				Hrs. Min.	8. Date of Birth (Month, Day, 4/17/19		9. Birthi	place (State or Foreign ntry)		
	yland		Usual Residence of Decedent 10a. State 10b. County			0c. City, Town		ation		•				10d. Inside City Limits	
	the Mar r 28a-f st	Director	Md. Mont	gomery		Rockvi	lle	10f. Zip Code			10	g. Citizen of W	hat Cou	tx⊡Yes 2 ☐ No ntry?	
36	rurs after death with the Marylar al', or Items 23a or 28a-1 show Ext. vir et must be notified at	Funerai	6111 Montrose 11. Marital Status 1 Never Married 2 Mar	ried 1 ☐ Yes If Yes, G	2 ⊋No ve	er in U.S.	t	208 as Decedent of Hi Yes, specify Cuba		n? (Spec Puerto F	cify Yes or No- Rican, etc.)		White,		
$\mathcal{SOAR}_{\mathcal{SOR}}$ altimore, Maryland 21215-0036	"natur	Completed by	3℃ Widowed 4 □ Divorced 15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	Year or E it's Education st grade completed) College (Decede (Give ki life. De	nt's Usual Occupi nd of work done o NOT use retired	ation luring most o	f workin	19		Kind of Business/Industry Retail shoes		
land 2	2 should be filed within and Mental Hygiene. is marked other than aumalic event, Ira M.	To Be Co	17. Father's Name (First, Middle, Joseph Sava	_			Dare				(First, Middle, M Meyers				
Mary	d 2 Tis		19a. Informant's Name/Relations Joseph Zang/				•	Address (Street a					State, Zij	o Code)	
SOAM Itimore	<u> </u>		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5	3 Removal from	State		y, crema	tion (Name of tory or other plac th Israe		D: 3/07		Oc. Location - C			
Balt.	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike Rockville, Md. 20852												
ROSE O,	Physician /Medical Examiner the prival-transit the prival-transit	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	oach line. TA (or as a co	consequence of	of):	C BL			R CA		R	Approximate Interval Between Onset and Death	
7 ANG, F. 9. P.O. Box 68760,	that the death certificed by the attending I	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditi	4□Pregi 9□Unkr	oirth 2 on nant at tin own	Fetal death	5 🗆 (ctopic pregnancy Other (specify) erlying cause give	on in Part I.		23e. Did tob	23d. Date Mon	th	ery Day Year he cause of death?	
l Records	The law requires ate has been sign page 2 should be	Completed b									1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. W	ere auto	pospsy findings available impletion of cause of	
Division of Vital Records,	il or Attending Physician: Thatler death. Director: Atter this certificate In by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Marger of Death 1 Natural 5 Pendii investi 2 Accident investi 3 Suicide 6 Could determ	Hospital: 1 28a. Date (Monggation			ime of njury	3 DOA Other 28c. Injury Work 1 1	r: 4 Nursi	ng Hom	hath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Nur City or Town, State)				
D	pita Pral Bral	ledical Cer		ng Physician: To the Examiner: On the b	best of r	my knowledge kamination and	, death	occurred at the tim							
•	To the Hosi within 24 ho To the Fun completely f	Me	29b. Signature and title of certifie	M)			29c. License	number 0610	96		d. Date signed $5/6/$	(Month,	Day, Year)	
ı	Sta Registr		30. Name and address of person 31. Date filed (Month, Day, Year,	APALL	- 1	th (Item 23a) (M	ONITRE	SEI	RD/	D RO	CKYIL	LE,	MDZ085.	

DHMH 17 Rev 1/2001

		1 - For State Of State Of Registrar	Maryland / De	ertificate of		Reg	. No. or page	7, 151.01			
Physici /Medic		1. Decedent's Name (First, Middle, Last) John Douglas Zege	er			2. Date of Death Month May	Day Year 7 2007	3. Time of Death 3:40 PM M			
Examin		4a. Facility Name (If not institution, give street and number NMS Health Care	·		r Location of Death Hagerstow		ton County				
Funeral Director		5. Social Security Number 217–42–9699 6. Sex Will M 2 F	. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You April 20	ear) Co	thplace (State or Foreign ountry) Maryland			
f show	or	10a. State 10b. County Maryland Washington	10c. City, Town or	vn or Location 10d. Inside Cit Hagerstown 1월yes							
illed within /2 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	1 Director	10e. Street and Number 320 McDowell Avenue		10f. Zip Code	21740	10g	. Citizen of What C	ountry?			
ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deced Armed Ford 1 Yes 2 If Yes Give Year or Date	2. □Mo	3. Was Decedent of H If Yes, specify Cub 1 Yes 2 No	dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
ene. than "natura ne Medical E		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+) (Gi	cedent's Usual Occup ive kind of work done e. DO NOT use retire Self Emplo	during most of work d)	ing	b. Kind of Business/Industry Horse Racing Industry				
dod	To Be Co	17. Father's Name (First, Middle, Last) Roy Milton Zeger		beir impre	18. Mother's Name	First, Middle, Ma	iden Surname)	mg moustry			
3 C 3		19a. Informant's Name/Relationship (Type. Print) Roy D. Zeger (son)		, City or Town, State, Zip Code)							
nent of Health int: If Item 27 iry or other tra		20a. Method of Disposition 1 \(\begin{align*} \text{Secision} & \text{Secision} \) 4 \(\end{align*} Donation \(5 \end{align*} \) Other \(Specify \)	20b. Place of Dis	sposition (Name of crematory or other place aven Cemet	ce)	Date 20	c. Location - City or				
Department of Important: If It any Injury or conce.	_	21. Signature of Funeral Service Licensee		22. Name and Addre	ess of Facility Do	uglas A.	Fiery Fu	neral Home yland 21742			
hysician /Medical		23a. Part1. Enter the disease, or complications that constant shock, or head failure. List only one cause on earling mediate Cause (Final disease or condition resulting in death) a. Due to (or missing in the constant of t	r as a consequence of):	enter the mode of dyi	ng, such as cardiac		t,	Approximate Interval Between Onset and Death			
physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or Due to (
by the attending p tached for use as	Physician/Med	in the past 12 months?	nt at time of death	3 ∐Ectopic pregnanc 5 Other (specify) _	у		23d. Date of de Month	elivery Day Year			
gned be de	þ	Part II. Other significant conditions contributing to dea	ath but not resulting in the					o the cause of death? Probably 4 [D] Inknown			
certificate has been si irector, page 2 should l	Completed	antoning like				24a. Was an autopsy performe	prior to				
s certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 In	patient 2 ☐ ER/Outpat	tient 3 DOA Oth	nor:	h (Check only one)	ce 6 □Other (Spi	acify)			
er deatn. rector ; After this i by the funeral di	Certification: To	27. Manner of Death 1 Description 1 Description 28a. Date or (Month) 28a. Date or (Month) 28a. Date or (Month) 28a. Date or (Month)		e of 28c. Inju	ry at rk?]Yes 2 □ No	28d. Describe how	injury occurred	iural Route Number,			
ours aft eral Di filled in		determined 200. Flace (g, etc. (Specify)			City or Town,	State)				
in 24 ho the Fun pletely	Medical	(Check only one) 2 Medical Examiner: On the ba	sis of examination and/o	r investigation, in my	opinion, death occur	red at the time, date	e and place, and du	e to the cause(s)			
To the comple	Z	29b. Signature and title of certifier		29c. Licens	Se number		I. Date signed (Mon				
-0	ate	30. Name and address of person who completed cause VASA~~ DATT 31. Date filed (Month, Day, Year) 32. Re		pe, Print)	r HACE	ERSTOW	~, mo	21740			

Registrar

MAY 10 2007 Been S. South

DHMH 17 Rev 1/2001

			1 - For State Registrar		Marylar		artmen rtificat			and M	lental Hyg	jiene	07	154	92
	Physic	ian	Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	Day	Year	3. Time of	Death
4	/Medi		Lois Je			Ahl					May 20	, ^{Day} 200	7	9:05	Рм
	Examir	ner	4a. Facility Name (If not institution Joseph Riche					Town, or time	Location o	of Death		4c. Cour	4c. County of Death		
	Funeral Director		5. Social Security Number 219-32-4879	6. Sex 7. 1 ☐ M 2 ☐ XF	Age (In yrs. 69	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 1 – 1 6 – 1	938	9. Birth Cou Ten	place (State of intry) nesse	or Foreign
	and]	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside C	ity Limite
	he Maryl 18e-1 eho otililed	Director		timore			Dun	dalŀ	ς					1 🗆 Yes	
	23a or 2	ral Dire	7450 Durwood	Road			10f. Zip	212	22			0g. Citizen o	of What Cou S . A .	intry?	
960	72 hours after death with the Maryland "natural", or Iteme 23a or 28e-1 ehow idical Exam art must be multied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ঐ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2] If Yes, Give Year or Date	s? ⊠No		Was Deced f Yes, spec 1 \(\text{Yes} \) 2		spanic Orig n, Mexican Specify:	gin? (Spi , Puerto	Rican, etc.) Black, V			merican Indian, thite, etc. Vhite	
21215-0036	within ene. than "	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 8th	's Education t grade completed) College (1-4c	or 5+)		dent's Usua kind of wor DO NOT us emak	rk done d se retired)	tion u <i>ring m</i> ost	of worki	ing	16b. Kind of	Business/Ir		
d 2	be filed tat Hygind other	Be Co	17. Father's Name (First, Middle, I	_ast)					18. Mothe	r's Name	(First, Middle,				
Maryland	should be nd Mental marked o	To B	Orville 19a. Informant's Name/Relationsh	i- (T Orient	1	Dixon				Mab	el	Pen	ny		
Ma	C 40 -										A Route Number				566
	Head The	Joseph Ahl - Son 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 99 Tide Mill Lane Hampton, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. L										20c. Location			700
Ę	Pages nent of int: if it		1 🖾 Burial 2 □ Cremation 4 □ Donation 7 5 □ Other (Sp							-24-	-2007 I	Baltin	nore.	Mary	land
Baltimore,	permit. Page Department of important: if eny injury or once.		21. Signature of Funeral Service L	The state of the s		22	. Name and	Address	of Facility	y	- Tr	Funo		Uomo.	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the death	h. Do not ente	263 S or the mode	of dying	onkl	ing	Stree	t Bal	to.	MD 21	224 •
	Physician	2 g	Immediate Cause Final disease or condition resulting in death)	a Me	astat		G ca							Interval Bet Onset Ind I	ween Death
	/Medical Examiner	-	Due to (or as a consequence of): Sequentially list conditions.												,,
8760,4	death certificate be executêd e attending physicien and ed for use as the burial-transit	al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ										
687	ficate phys s the	0.											-		
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pre Other (spe					23d. Date of deliven			fear		
	8 P 8	ρ	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the un	derlying ca	iuse giver	n in Part I.				/	he cause of d	
Sor	* requ	etec										s 2 No		oably 4 ⊟U	
al Re	n: the lav ficete has r, page 2:	Completed		6000						_	24a. Was a autops perform	y	prior to co death? 1 \(\text{Yes}	opsy findings a impletion of ca 2 \square No	ivailable luse of
₹ :	Physician: this certificatal director, i	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tions O 🗆	FD/Outerties	a 🗆	104.			Check only on	VA.		11	,
Division of Vital Records,	ro the hospitel of Atlanding Prystician: the within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Accident investigation	28a. Date of In (Month, L	ijury	ER/Outpatient 28b. Time of Injury		c. Injury a Work?	4 Li Nui:	2	ne 5 Reside 8d. Describe ho	-	ther (Specif	W) Hesp	ce
Divis	a after de	Sertific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 28e. Place of I	njury - At ho etc. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (St. City or Town	eet and Nun , State)	ber or Rura	al Route Numi	ber,
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1	withi To th		29b. Signature and title of certifier				29c.	License	number		Dey, Year)				
			1 2 tso h	(A)			D24170 P					May	Lay 21, 2007		
	6		30. Name and addre s of person w	ho completed cause of	death (Item	23a) (Type, F	Print)			0	ltimore				
			31. Date filed (Month, Day, Year)	ichey Hospi	trar's Signat	38 N.	Eut	aw S	+	Ba	ltimore	MD	212	e i	
	Sta Registra		MAY 2 2 20		Jan 3 Gignat	freed.	2								

Lois Ahl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay 19, **Physician** ESLIE 520 A 2007 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellamont Himore NIA North If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) last birthday) Funeral 1 M 2 □ F Months 21-042 Yrs. Director JAMAICA Usual Residence of Decedent 10b. County 10c. City, Town or Location a or 28a-f show t be notified at 10d. Inside City Limits 1 Yes 2 No Funeral Director 10e. Street and Number Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23a or r items 23a iner must b USH 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Jral", or item Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Be Completed by Specify. 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Drochart: If them 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 +HGRADE RITE AID PHARMAC 17. Father's Name (First, Middle, Last) (UNKNOWN) Maryland 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MELITA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State TRO CREMATORY 05-21-07 BALTIHORE, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility & Himore 21. Signature of Funeral Service Licenses MD. 2140 NO FULTON bseph H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -UNG CANCER Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 □ Yes 1 Yes 2 1 No 2 1 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Iniury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

MAY 2 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

KAISH

2007

N. EUTAW ST # 305 BACTIMONEMA

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Baltimore, Maryland 21215-0036

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Division or Vital Records, P.O. Box 68760, 😞	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after dooth	in 1.5 miles are used and account to the third physician and the Funeral Director; After this certificate has been signed by the attending physician and ripletely filled in by the funeral director, page 2 should be detached for use as the burial-fransit

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Examin	er		-	ive street and number,)		4b. City, Town,				4c. Cou	inty of Death	
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Funeral Director		054-28-20	097	1□M 2໘F	76	Yrs	Months Day		Min.	(Month, Day	y, Year)	Cou	ran
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	Asdouria Position	n Son	20b. F	Place of Di	BO Hess Ro sposition (Name of		Dat	on, Ma		1 210 on - City or T	
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69.40		23a. Part1. Enter the shock, or hear	he disease, or 🗴 r rt failure. List 🕶	mplications that cause y one cause on each l	d the deat ine.	h. Do not	enter the mode of d	ying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
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5		CATHERINE GALLAGHER MO UNION MEMURIAL HUSPITAL, MO											
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. To Be Completed by Funeral Director

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Examiner	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and promise the complete of the funeral director.

Division or Vital Records, P.O. Box 68760,

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Registr

Frank T. Baker, Sr. 19a. Informant's Name/Relationship (Type. Print) Marie S. Baker Wife Mary Mary Mary Mary Mary S. Westgate Road, Owin	2. Date of Dea Month May 21 8. Date of Birth (Month, Day) Feb. 10 10 11 12 12 13 14 15 16 16 17 17 17 18 18 18 18 18 18 18	Day Year 2007 4c. County of Dea Balt: 3, Year) 9. Bi Color, 1936 14. Race - Am Black, Whi Specify: 16b. Kind of Business Industri Maiden Surname) 7, City or Town, State, 1, MD 2111 20c. Location - City or Sykesville	4:30PM ath imore Inthplace (State or For Journity) Maryland 10d. Inside City Lir 1 Yes 2 X Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry? A Jountry A Jount										
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9 ☐ Unknown		Month	Day Year										
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	24a. Was ar autops		utopsy findings availa										
	perforn	ned? death? 1 Yes	·										
5. Was case referred to medical 26. Place of Deat			2 23110										
examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho		nce 6 Dother (Spe	acifu)										
7. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho		ony)										
1 Natural 5 Pending (Month, Day Year) Injury Work?" 2 Accident investigation M 1 Yes 2 No													
3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office	28f, Location (Str	reet and Number or Ri	ural Route Number										
4 ☐ Homicide determined building, etc. (Specify)	City or Town	, State)	a.a. House Hallings,										
9a. Certifier 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	auea(e) and m	a atatad										
(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence.)	red at the time da	ate and place and due	a to the causo(s)										
and manner stated. 9b. Signature and tittle of certifier 29c. License number		Nd Date store 1 (15)	56 Den 14										
29C. Licerise flumber	29	ou. Date signed (Mont	m, Day, Year)										
D885+802		May 22,	100 F										
0. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
Jells Messersmith, MD 401 North Brondway		A 4											
I. Date filed (Month, Day, Year) 32. Registrar's Signature	Baltimo	re, Mara	land 2123										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Η. Briemann 2007 3:40 A M 21 /Medical MAY 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Atlantic Rehab Center Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. Dec. 14 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ☑ F Months 213-30-9560 73 Director MD Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Director 1 ☐ Yes 2 No Delaware Sussex Selbyville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "naturai", or items 23a or traumatic event, the Medical Examiner must be in 37034 Fawn Drive 19975 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Worker Box Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James R. Sands Olive Thompkins ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George H. Briemann Sr. (spouse) 37034 Fawn Drive, Selbyville, DE 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Cemetery Glen Burnie, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, aph line. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner at uny, reading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Day Month Year 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Suursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Accident 5 ☐ Pending investigation hours after death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 28269 Name and address of person who completed cause of death (Item 23a) (Type, Print) Coastal Haling F Porsdulie 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 2 2007 Registrar

BRIEMANN, THEDA

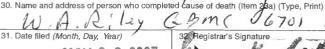
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			1 - For State Registrar	State of Maryland / I	Department of H Certificate of L			07 10431
	Physic	an	Decedent's Name (First, Middle, Last)	2	2. Da	Reg. No. ate of Death onth Day	3. Time of Death
	Physici /Medi	cal	James	Thomas:	Doulwa	ire n	19 17	2007 431AM
1	Examir	ner	Baltimore VI	+ Medical Cen	ter Bal	Location of Death	4c. Coun	ty of Death
	Funeral Director		5. Social Security Number 6. Se 212-30-0255 Usual Residence of Decedent	7. Age (In yrs. last bit	rthday) If Under 1 Year Yrs. Months Days		ite of Birth Jonth, Day, Year)	9. Birthplace (State or Foreign Country) SOLITH CAROLINA
	show		10a. State 10b. County	10c. City, Tow	m or Location			10d. Inside City Limits
	he Mai	ector	MARYLAND N.	'A		TIMORE		1√1Yes 2□No
	3e or 2	0	10e. Street and Number	ER AVENUE	10f. Zip Code	21225	10g,/Citizen of	What Country?
	r death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yn, Mexican, Puerto Rican,	es or No- 14. Ra	ace - American Indian, ack, White, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Madical Examinat must be rodified at	ed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 Ø No	Specify:	Spec	ity: BLACK
215-	hin 72 on "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. le completed) College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	uring most of working	16b, Kind of	Business/Industry
	filed with Hygiene. Ither ther	Com	12+HGRADE	College (1-407 5+)	LABOR	ER	GASC	+ ELECTRIC CO.
Maryland	d be fill	Be	17. Father's Name (First, Middle, Last)	Baul	1.1005	18. Mother's Name (First	, Middle, Maiden Suma	me)
aryl	should be and Mental is marked c	-H	19a. Informant's Name/Rel- ionship (T)	rpe, Print) 19t	. Mailing Address (Street a	, , , , , , , , , , , , , , , , , , , ,	e Number, City or Town	n, State, Zip Code)
_	ges 1 and 2 it of Health a if item 27 is or other trei		CHARLES JOHNSO. 20a. Method of Disposition 1X Burial 2 Cremation 3 GF		02 35H 1 Disposition (Name of ry, crematory or other place	OP AVE.	BALTIMOR 20c. Location	EMD 21215 Lity or Town, State
Baltimore,	Pa men ant: ury		' 4 Donation 5 □ Other (Specify)	a a CROW	INSVILLE CE	7.2100		SVILLE, MD.
Bal	permit. Departi Importi any inj		21. Signatura of Funeral Service Licens	6. Koare	22. Name and Address	of Facility BRO	WN JR. FO	INERAL HOME TO, HD 21217
			23a. (1. Enje) the disease, or complete stock, of beart failure. List only of	ications that caused the death. Do ne cause on each line.	not enter the mode of dying	, such as cardiac or resp		Approximate Interval Between
-3	Pnysician		Impodiate Cause (Final disease or condition resulting in death)		ell Carcina			Onset and Death
ı	/Medical Examiner			Due to (or as a consequence	of):			
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68760,	ifficate be executed g physician and as the burial-transit	edical E	L,	1.	····			
_	± σ σ		IF FEMALE:					
.O. Box	The law requires that the death cert tle has been signed by the attending page 2 should be detached for use a	Physiclan/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			ate of delivery onth Day Year
Ω.	es that igned b	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause give	n in Part I. 23	Be. Did tobacco use cor	ntribute to the cause of death?
ord	w require been sig should b	ted	Malnourished				1 ☐ Yes 2 ☐ No	3 Probably 4 □Unknown
Vital Records,	The law sate has b page 2 st	Completed					la. Was an 24b. autopsy performed?	Were autopsy findings available prior to completion of cause of death?
tal		o l	25. Was case referred to medical			26. Place of Death Chec	Yes 22 No	1 ☐ Yes 2 ☑ No
of V	Physicien: this certificated director,	To B	1 105 20 190	lospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Other			her (Specify)
ono	ng fter inei	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Fime of 28c. Injury Pork* M 1 □ Y	at 28d. De ? es 2 ☐ No	escribe how injury occu	rred
Division	Hospitel or Attending 4 hours after death. Funerel Director: After tely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)		28f. Lo	cation (Street and Num by or Town, State)	ber or Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sicien: To the best of my knowledge ner: On the basis of examination an and manner stated.	death occurred at the time d/or investigation, in my opi	e, date and place, and du- inion, death occurred at the	e to the cause(s) and m ne time, date and place,	anner as stated. and due to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier	?	29c. License	number	29d. Date sign	ed (Month, Day, Year)
			Minue 1	Serve Mr	0 0	1179	May	, 17, 2007
	341		30. Name and address of person who co Hime Bennis	10 41 6	- 1	+ Baltimo	ore mo	21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature				
DH	Registr MH 17 Rev 1/20		MAY 2 2 2007	Marine St 1	bank			
				ORK	GINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Linwood William Brice, /Medical May_ 2007 6:10 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center Towson Baltimore Co. 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 XM 2 ☐ F Director 212-24-8536 Aug. 3,1929 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits be notified at 1 ☐ Yes 2√ No 28a-f Maryland <u>Baltimore</u> Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 1862 Church Road Funeral 21222 Pages 1 and 2 should be filed within 72 hours after death United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No ð Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. 127 is marked other than "1 188 traumatic event" Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Restaurant Owner <u>Crab Net Restaurant</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenwood Brice 2 Thelma Travers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 or other tra Mrs. Shirley E. Brice (Wife) 1862 Church Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If Ite
any injury or ott
once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation \$5₺ Other (Specify) Entombnen Oak Lawn Cemetery 5/21/2007 Baltimore, Maryland 21. Signatu e of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the shock, or hear sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fure. List only one cause on each line. Immediate Cau e (Final disease or condition resulting in death) Physician Unotat. colon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760. use as IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death signed by the a o 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy perform 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**o 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury ours after death.
neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital within 24 hours a To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) MAY 2 2 2007



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N. Charles St. Balts. Md 2120%

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07-03749

Paul Wayne Burton, Sr.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 15493

	R	egistrar				Cerun	cate of t	Deam			- 10		Reg. No.			3. Time of Death
Physicial xamin	n/ 1 ler	Decedent's Name (First, Middle				Burt	on, Si	r				Date of De Month May 16,	2007	Yea	ar	2351 hrs
Service .		4a. Facility Name (if not institution 7909 Trappe Road #A		reet and nu	imber)		41	o. City, Tow Dundalk		ocation of			E		re Cour	
Funeral Director	5	5. Social Security Number	6. Sex	2 F		n yrs. last b	oirthday) Yrs.	if Under 1 Months	Year Days	If Under Hours	24Hrs. Min.				Foreigr	nplace (State or ⁿ ^{ntry)} Maryland
Billostor	L	217-54-2274	IX IVI	2	57		110.					Marc	<u>nı></u>	195	U	
any		Usual Residence of Decedent 10a. State 10b. County			10	c. City, Tov	vn or Locatio	n								10d. Inside City Limits
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Maryland 28a-f show d at once.	핡		<u>alti</u>	more				10f. Zip Co	ode		ninga	IK .	10g. Cit	izen of W	hat Coun	try?
e Mar or 28a	Director	10e. Street and Number 7909 Trappe Road Apt. A 21222									TIm	i+04	Sta	tos		
with the Maryland ms 23a or 28a-f sho be notified at once		/ Man Decedent of Hispanic Origin? / Sne								cify Yes or		can Indian, Black,				
th wi	uneral	11. Marital Status1 Never Married 2 M	arried	Armed F	orces?	3	If Ye	es, specify (Cuban,	Mexican,	Puerto R	tican, etc.)		Whi	te, etc.	
or dea	교		vorced If `	X Yes Yes, Give Ye	2 ear	No	1	Yes 2 >	No	specify:				Specify:		White
"natural", or	<u>a</u>	15. Decedent's Education (Spe	or	r Dates:		eted) 16	Sa Decedent	's Usual Oc	cupati	on (Give k	ind of wo	ork done	16b.	Kind of E	Business/I	ndustry
"nate	Completed	Elementary/Secondary (0-12)			(1-4 or 5+)		during mo	ost of working	ng life.	DO NOT	use retire	ea)				
5-0036 iled within 7/ Hygiene. I other than the Medical	희	8 Years					Pa	ainter		Construction					tion	
d with	탉	17. Father's Name (First, Middle	, Last)						1	8. Mother's	s Name (First, Middl	e, Maide	n Surnam	ie)	
215 be file ntal H	Be (Robert Burt	on								Ma	ttie	<u>Gill</u>	ispi	e	7:- 0-4-\
21, buld b	m Robert Batter Burton, Print (Son) 19b. Mailing Address (Street and Number or Rural Route Number, Con) 3405 McShane Way Dundalk, Mar															
MD 2 should be s		Mr. Paul W. Bu	rton	, Jr.					Dun	idalk, Date	dalk, Maryland Date 120c. Location -			222 Town, State		
e, le land Heal Heal	/.]	20a. Method of Disposition 1 Burial 2 Crematic	n 2	Demoval	from State	1	ce of Dispos matory or oth	ition (Name ner place)	or cen	netery,		Date	200	, Loodiioi	i Oity oi	, , , , , , , , , , , , , , , , , , , ,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Nental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	4	4 Donation 5 Other S		Removal	nom otate	Hil	1top S	Servi	ce_C	corp.	5/2	1/200	7	Tows	on,	Maryland
altir nit. I partm porta nry o		. Signature of Funeral Service	e License		12		7	lame and A Ouda-P	77	- Dann	Cral	Home	of	Dund	alk	Inc
ii ii ji ji ji ji		23a. Par I. Enter the disease, or	(6	U	<u> </u>	1 '	7922	Wis	: Av	e.	Dunda	1k	Mary	land	21222 Approximate Interval
vsician	<	23a. Par I. Enter the disease, of	r complica	ations that	caused	eath. D	o not enter t	he mode of	dying,	such as c	ar lac or	respiratory	arrest, s	ariock, or i	leart	Between Onset and Death
Ledical Examiner	1	Immediate Cause (Final diseas	e a	methao			ohol in	toxicat	ion							Dod.
or condition resulting in death) Due to (or as a consequence of):																
	_	Sequentially list conditions, if any, leading to immediate	b Dı	ue to (or as	a conseq	uence of):										
	nine	cause. Enter Underlying Caus (Disease or injury that initiated														
ted 1 ansit		events resulting in death) Last Due to (or as a consequence of).														
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the filteral director, page 2 should be detached for use as the burial - transit	ical	WINDED AMENDED #23a,27,28a-f. perMF., g867, 5/29/07 TT IF FEMALE: 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 21b. Live birth 2 Fetal death 3 Ectopic pregnancy Month														
60, ite be hysici	Med	π.Σ.α, 27, 20.α-1. pen/ir., 980/, 5/29/0/ TI IF FEMALE: 23c. If yes, outcome of pregnancy												of delive		
68760, certificate bd nding physic	an/I	23b. Was decedent pregnant in past 12 months?	the		e birth	ince of door		etal death	3	Ectopi	ic pregna	incy	Ì	Month	1	Day Year
Box 687 ne death certific the attending pred for use as the	sicia		Jnknown		egnant at t known	ime of deat	ⁱⁿ 5 0	ther (Spec.	ify)				-			
. Bc he de: y the :	Phy	Part II. Other significant cond	ditions (h		but not res	ulting in the	underlying	cause	given in P	art I.					o the cause of death?
P.O.	ğ	, att in other organization			-							1	Yes 2	No No	3 🗸 Pro	obably 4 Unknown
ords, P.C w requires that s been signed I should be deta	ted												Was an	24	b. Were a	autopsy findings available completion of cause of
SOFC law re has be 2 sho	흝								_				erforme		death?	
Division of Vital Records, tal or Attending Physician: The law requirer as after death al Director. After this certificate has been siled in by the timeral director, page 2 should be an order of the control of the co	Completed								26 Plac	e of Death	n (Check		es 2	INO	· •	163 2 110
cian:	Be	25. Was case referred to med examiner?		ospital:	Inpatier	at 2 F	ER/Outpatier		OA	Other,		ng Home	Res	sidence	6 🗸 Oth	er: Scene
of Vit ing Physic After this uneral dir	P	1 ✓ Yes 2 No 27. Manner of Death		28a. D			28b. Time of			ury at Wo	rk?	28d. Desc	ribe how	injury oc	curred	
n of 'ding Ph	i ii	1 Natural 5 Pe	ending	5/16	ate of Injur onth, Day, Ye 5/2007	ear)	Fnd 11:	/17 pm	1	Yes 2	No	unk				
VISIOR or Attend after death Director:	cati	2 Accident In	vestigatio	28e F	-		me, farm, str		, office	building,	etc.	28f. Locat	ion (Stre	et and Nu	umber or I	Rural Route Number, City
Divipital or ours after ours after ours after ours after ours after ours after ours after ours ours after ours ours after our ours ours ours ours ours ours ours	Certification:	3 Suicide 6 AC	ould not be etermined	e		sidenc						7909 ⁷ °	rapp	è Rd,	Dunda	alk,MD
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the			Physicis	Takha	hast of m	knowledg	e death occ	urred at the	time,	date and p	olace, an	d due to the	cause(s) and mai	nner as st	ated.
To the Hos within 24 h To the Fun completely	Medical	(Check only 1 Certifying one) 2 Medical E	xaminer:	On the ba	sis of exar	nination an	d/or investig	ation, in my	y opinio	n, death o	occurred	at the time,	date and	place, a	nd due to	the cause(s)
and manner stated. 29c. License number 29d. Date signed (Month, Day, Y)										fonth, Day, Year)						
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1		30. Name and address of per			/		23a)				_					
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death **Physician** Month Day CHARLES E. BROCKWAY May 20, /Medical 2007 12:48 p^M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 14 W Ridge Road Greenbelt Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Days Months 1**X** M 2□ F 93 Director 261-28-8372 06-22-1913 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits aţ ns 23a or 28a-f sh must be notified Director 1 X Yes 2 □ No Maryland | Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 14 W Ridge Road Funeral 20770 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married 1 X Yes 2 No 1942— If Yes, Give Year or Dates: 1946 Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No <u>ک</u> Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than College (1-4or 5+) 11 Security Guard US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Pierce Brockway Amanda Jane Rexrode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nettie Brockway - Wife Ridge Road, Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite any Injury or ot 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Miller Cemetery 05/23/2007 Clark's Merrit, PA 21. Signature of Funeral Service 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one car's on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ε and Due to (or as a consequence of): Physician/Medical as the attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2: autonsy performed? /es 2 X No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death : After t 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Meet D23743 05/21/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Drive, Greenbelt, Maryland Martin Weltz, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Margare